IMPACT OF THE DRG SYSTEM IN ARIZONA

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

SEPTEMBER 14, 1985, TUCSON, AZ

Printed for the use of the Select Committee on Aging

Comm. Pub. No. 99-529

U.S. GOVERNMENT PRINTING OFFICE
54-636 O WASHINGTON : 1986

H141-19

SELECT COMMITTEE ON AGING

EDWARD R. ROYBAL, California, *Chairman*

CLAUDE PEPPER, Florida
MARIO BIAGGI, New York
DON BONKER, Washington
THOMAS J. DOWNEY, New York
JAMES J. FLORIO, New Jersey
HAROLD E. FORD, Tennessee
WILLIAM J. HUGHES, New Jersey
MARILYN LLOYD, Tennessee
STAN LUNDINE, New York
MARY ROSE OAKAR, Ohio
THOMAS A. LUKEN, Ohio
BEVERLY B. BYRON, Maryland
DAN MICA, Florida
HENRY A. WAXMAN, California
MIKE SYNAR, Oklahoma
BUTLER DERRICK, South Carolina
BRUCE F. VENTO, Minnesota
BARNEY FRANK, Massachusetts
TOM LANTOS, California
RON WYDEN, Oregon
GEO. W. CROCKETT, JR., Michigan
WILLIAM HILL BONER, Tennessee
IKE SKELTON, Missouri
DENNIS M. HERTEL, Michigan
ROBERT A. BORSKI, Pennsylvania
FREDERICK C. BOUCHER, Virginia
BEN ERDREICH, Alabama
BUDDY MacKAY, Florida
HARRY M. REID, Nevada
NORMAN SISISKY, Virginia
ROBERT E. WISE, JR., West Virginia
BILL RICHARDSON, New Mexico
HAROLD L. VOLKMER, Missouri
BART GORDON, Tennessee
THOMAS J. MANTON, New York
TOMMY F. ROBINSON, Arkansas
RICHARD H. STALLINGS, Idaho

MATTHEW J. RINALDO, New Jersey,
Ranking Minority Member
JOHN PAUL HAMMERSCHMIDT, Arkansas
RALPH REGULA, Ohio
NORMAN D. SHUMWAY, California
OLYMPIA J. SNOWE, Maine
JAMES M. JEFFORDS, Vermont
THOMAS J. TAUKE, Iowa
GEORGE C. WORTLEY, New York
JIM COURTER, New Jersey
CLAUDINE SCHNEIDER, Rhode Island
THOMAS J. RIDGE, Pennsylvania
JOHN McCAIN, Arizona
GEORGE W. GEKAS, Pennsylvania
MARK D. SILJANDER, Michigan
CHRISTOPHER H. SMITH, New Jersey
SHERWOOD L. BOEHLERT, New York
JIM SAXTON, New Jersey
HELEN DELICH BENTLEY, Maryland
JIM LIGHTFOOT, Iowa
HARRIS W. FAWELL, Illinois
JAN MEYERS, Kansas
BEN BLAZ, Guam
PATRICK L. SWINDALL, Georgia
PAUL B. HENRY, Michigan
JIM KOLBE, Arizona
BILL SCHUETTE, Michigan

FERNANDO TORRES-GIL, *Staff Director*
PAUL SCHLEGEL, *Minority Staff Director*

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

CLAUDE PEPPER, Florida, *Chairman*

JAMES J. FLORIO, New Jersey
HAROLD E. FORD, Tennessee
MARY ROSE OAKAR, Ohio
THOMAS A. LUKEN, Ohio
DAN MICA, Florida
HENRY A. WAXMAN, California
MIKE SYNAR, Oklahoma
BUTLER DERRICK, South Carolina
BRUCE F. VENTO, MINNESOTA
BARNEY FRANK, Massachusetts
RON WYDEN, Oregon
IKE SKELTON, Missouri
DENNIS M. HERTEL, Michigan
ROBERT A. BORSKI, Pennsylvania
BEN ERDREICH, Alabama
BUDDY MacKAY, Florida
NORMAN SISISKY, Virginia

RALPH REGULA, Ohio,
Ranking Minority Member
GEORGE C. WORTLEY, New York
JIM COURTER, New Jersey
CLAUDINE SCHNEIDER, Rhode Island
THOMAS J. RIDGE, Pennsylvania
JOHN McCAIN, Arizona
SHERWOOD L. BOEHLERT, New York
JIM LIGHTFOOT, Iowa
JAN MEYERS, Kansas
PATRICK L. SWINDALL, Georgia
PAUL B. HENRY, Michigan
JIM KOLBE, Arizona

KATHLEEN GARDNER CRAVEDI, *Assistant Staff Director*
MARK BENEDICT, *Minority Staff Director*

CONTENTS

Members' Opening Statements

	Page
Jim Kolbe	1
John McCain	4

Chronological List of Witnesses

Panel one:	
Vivian Soash, State of Arizona	6
Ula Sabisch, State of Arizona	11
Otto F. Dworsky, president, Arizona Federation of Chapters, National Association of Retired Federal Employees	12
Frances Smith, American Association of Retired Persons	14
Panel two:	
Robert D. O'Connor, regional administrator, Health Care Financing Administration	22
Dr. Theodore H. Koff, director, Long-Term Gerontology Center, University of Arizona Medical Center	28
Dr. Donn Duncan, practicing physician, State of Arizona	32
Dr. Lawrence Shapiro, Peer Review Organization, State of Arizona	37
Panel three:	
Dr. Gary Henderson, president, Arizona State Medical Association, Tucson, AZ	46
Tom Plantz, chairman, Board of Directors, Arizona Hospital Association	61
Robin A. Klaehn, regional administrator for Medical Personnel Pool in Arizona	69
Panel four:	
Stewart Grabel, director, Cochise Aging Services	81
Kathleen Heard, director, Area Agency on Aging, Southeastern Arizona Governments Organization, Bisbee, AZ	85

Audience Participants

Michael Smith, Pascua Yaqui Tribe	93
David Ramirez, chairman, Pascua Yaqui Tribe	94
Francisco Jose, vice chairman, Papago Tribe of Arizona	95
Jackie Kechnic, Council House,	97
Warren Scriber, Independent Insurance for Home Care	98
Elaine Owens	99
Jim Murphy, director, Pima County's Department of Aging	99
Ms. Bemis	100
Geraldine Leach, Elfreda and Cochise Counties	101
William Scott, Bowie, AZ	101
Dr. McClain, patient and family services, Tucson General Hospital	102
Eileen Glickman	102
Jo Kline	103

IMPACT OF THE DRG SYSTEM IN ARIZONA

SATURDAY, SEPTEMBER 14, 1985

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE,
Tucson, AZ.

The subcommittee met, pursuant to notice, at 9:40 a.m., in the auditorium of St. Joseph's Hospital, 350 North Wilmot Street, Tucson, AZ, Hon. Jim Kolbe (acting chairman of the subcommittee) presiding.

Members present: Representatives Kolbe and McCain.

Staff present: Paul Schlegel, minority staff director of the Select Committee on Aging; Lorne Craner, staff assistant to Representative Kolbe.

OPENING STATEMENT OF REPRESENTATIVE JIM KOLBE

Mr. KOLBE. Call the meeting to order.

This is a meeting of the Subcommittee on Health and Long-Term Care.

Let me begin by thanking all of you who are here. We are delighted, as I said a moment ago, to have such excellent attendance this morning. And I think it's an indication of the great interest that we have in this issue. I would apologize for those that are not able to sit in this room, but very pleased that St. Joseph's has been able to make alternate arrangements so that everybody can listen to and watch the proceedings from the cafeteria on the monitors.

I want to pay special thanks to St. Joseph's Hospital for making this facility available and for the outstanding work they have done to make the arrangements work so well here. They have provided for continuous coverage of us and a video tape of the proceedings, as well as the set up that has been provided here this morning. So I want to thank St. Joseph's and Carondelet Health Service for their help in making this hearing possible.

Let me begin by introducing my colleague and member of the Select Committee on Aging, Congressman John McCain, who represents Arizona's First Congressional District.

John, we are very pleased to have you here with us in southern Arizona this morning.

Also, I would like to introduce, up here, sitting with me, on my left Lorne Craner, who is my staff assistant for health care issues, and over on John's right, to your left, is Paul Schlegel, who is the staff assistant for the minority in the Select Committee on Aging, the Long-Term Health Care Subcommittee. We are very pleased to

have Paul with us this morning. He has been very helpful in preparing for this hearing.

VOICE. Ask him to turn his head around so we can see him.

Mr. KOLBE. We will begin—let me just tell you how the format is going to work here this morning, so everybody will understand. We will begin—Congressman McCain and I will have brief opening statements. Then we will go immediately to our first panel, who are already seated up here. We will take their oral testimony, and I want to make it clear to all of those who are here this morning to testify, either as part of one of the panels or later, that in the very brief 1-minute presentations at the end, any statements that you have that are longer, or you would like to have included in the record, will be included so that they will be available to the entire committee and subcommittee. So you do not need to feel that the testimony that you have prepared for this morning needs to be given in full, because it will be printed in the record.

To finish with the format, when we finish with each of the panels here, we will then go to questions. We will take questions of the entire panel, and then after all the panels are finished, we will begin with the call from the audience. We will have a microphone available in the audience to you there, and we would like to urge you, again, to limit the testimony to 1 minute, so as many people as possible can make their comments about this system.

VOICE. You mean our testimony is limited to——

Mr. KOLBE. No; calls from the audience will be limited to 1 minute testimony.

We will also take a very brief break between the second and third panel, so that our court reporter can stretch his legs, since he has to be on duty all the time during this. So we will take a very brief break.

The subject that we are discussing this morning, health care and the diagnostic-related group [DRG] system, is, I think, a very important one. America's health care delivery system is one of the best in the world. And the quality of health care in this country, most of us would agree, is of extremely high quality. Still, the best health care system in the world is useless if no one can afford it, and that is the point to which we were moving in the late 1970's and the early 1980's, when health care costs were escalating at between 15 and 20 percent each year.

Health care for the elderly has also experienced dramatic increases. In 1966, when Medicare was initiated, it cost the Government $3 billion. By 1983, the tab had increased to $57 billion. Worse, there was an acute danger that Medicare might have gone bankrupt in 1987 or 1988.

To stave off such a disaster, Congress, in 1983, enacted a series of reforms to the program that were designed to cut the costs and preserve the care.

A new method of Medicare reimbursement to hospitals known as the prospective payment system, was approved by Congress under title 6 of the Social Security Amendments of 1983. This is certainly one of the most significant changes in Medicare reimbursement policy since the Medicare Program was enacted in 1965. There is a 4-year phase-in for the program, and after that phase-in is completed, a hospital's reimbursement for treatment of a patient will be

based on a predetermined charge for the appropriate ailment category.

A Medicare patient entering a hospital is now assigned to 1 of 467 diagnostic-related groups, hence, the term DRGs. Each DRG covers a single ailment. A hospital thus usually knows in advance, based on the diagnosis of the patient when he or she is admitted, what it will receive for the treatment of that individual. If the hospital provides the necessary services for less than the allotted amount, it keeps the balance. And if the costs exceed the DRG payment, then it must absorb the loss. The system has been successful in ensuring that continued financial viability of the Medicare system.

It is estimated that the Medicare system will now be solvent, at least until 1998.

At long last, it was felt the new payment system was causing a much needed change in the hospital industry, which had, in the view of many observers, become too costly, as a result of the more you spend, the more you get mentality that was inherent, at least to some degree, in the old system. The new payment system is saving Medicare money and ensuring that the elderly people of the future enjoy the financial security of the program, but with significant progress being made on the cost-containment aspect of Medicare, health care providers, policymakers, and the elderly, themselves, are growing more and more anxious over the effects of this cost-containment system on health care access and quality.

There have been reports of significant problems in the delivery of health care under the DRG system of payments. And I know, from talking to some of my constituents, that there have been problems with the system here in Arizona.

Hospitals are a business. Not-for-profit hospitals must break even under the current system, and for-profit hospitals must make money, if they are to continue to provide a service to the community.

A recent poll conducted by the American Medical Association suggested that a significant number of physicians believe such pressures have already had a negative impact on medical care. Among other findings, the AMA said that 43 percent of the physicians surveyed said that hospitals have exerted unwarranted pressure to discharge patients early. Sixty-three percent of those responding said the quality of care has already deteriorated, or would deteriorate over time, with the new system.

Questions have also arisen concerning the adequacy of length of stay allowed under the individual DRG or diagnostic group.

There has been some evidence of dumping of more severely afflicted patients, those whose costs may quite obviously exceed the DRG allowance, because of complexity or complications, on the not-for-profit hospitals. Teaching institutions in particular, have become the dumping ground for those patients.

Because the DRG system is fairly new, there has to date been little hard data to determine the extent of such problems, and that is the point of this hearing today. We are here today to determine precisely what the problems are, and how widespread adverse effects of DRGs have been here in southern Arizona.

The question has become even more acute, because, by 1988, the DRG system will have been fully implemented for Medicare part A, the Hospital Insurance Program, which covers hospital and related institutional costs.

There is a move afoot in the Nation's Capital to extend the prospective payment DRG system to Medicare part B, physicians services, and a range of other health functions, including out-patient services and physical therapy.

This hearing is one in a series that are being held by members of the House Select Committee on Aging to ensure that efforts to cut health costs do not lead to a decline in the quality of care for Americans. We hope that these hearings will aid those of us in Congress in making an informed perspective and informed judgment on this question.

To aid us in determining the problems associated with DRG's, and the problems experienced in southern Arizona, I think we are very fortunate, today, to have an impressive series of witnesses, who will be discussing this issue with us. And I am particularly grateful to have with me on the panel this morning, my colleague in Congress, and on the Select Committee on Aging, Congressman John McCain.

Congressman McCain has served on the Select Committee since he was elected to Congress in 1982, and brings a deep understanding to the problems that senior citizens face. He also serves on the Foreign Affairs Committee in the House of Representatives, and, certainly of particular interest to those of us in Arizona, on the House Interior Committee. I would like to introduce Congressman McCain to make his initial statement.

STATEMENT OF REPRESENTATIVE JOHN McCAIN

Mr. McCAIN. Thank you very much, Jim. And thank you for convening the hearing today.

I think you have covered the topic very thoroughly. I will be brief, so that we can get to the important part of this hearing, and that is the testimony from our witnesses.

There is no doubt that the DRG system has made a major contribution toward reducing the costs of medical care for our senior citizens. There is also no doubt that there are problems associated with it.

The number of people and the interest displayed today, are ample testimony that there are refinements that need to be made in the system. I know of no one who seriously considers going back to the old system. But I do believe that there is great concern among many of our—not only our senior citizen population, but hospital administrators, government officials, and physicians, to ensure that we provide the proper level of health care.

It is entirely appropriate that 2 years since the enactment of the DRG system, we examine the hard data and statistics that we have been able to gather, and arrive at some reasonable and logical recommendations for legislative action to refine this system, and examine it overall, very carefully.

Why do we have field hearings such as this? I think that is an important question. From my experience in Washington, DC, ladies

and gentlemen, I can tell you that we have a great deal of information, but very few good ideas. The only way we are able to obtain the kind of information input we need to enact meaningful and important legislation is to come out and talk to the people who are directly affected by these programs.

I believe that the information we will receive today will be invaluable to us, to go back to Washington and tell our colleagues what it is really like, and what the problems and obstacles are that are being faced by all of our citizens, in order to provide an adequate level of health care.

Yes, we need to look at the DRG system, and determine whether this payment system has resulted in a decline of services and patient care to the elderly.

Additionally, we need to ensure that health care services are available in the rural areas and in anticipation of problems within the hospitals, Congress mandated the use of peer review organizations, to periodically review patient care. PRO's check DRG classifications, appropriateness of admission and discharge, out lier's status, and may even order hospital discharge for a patient.

The questions we must address are: Are these organizations performing their jobs effectively; and, do we need to do more to protect patient care.

The DRG system can be refined. Currently, the administration is examining the DRG system. One possible refinement would be to include a severity of illness index. All too often, under the present DRG system, the severity of illness in which a patient arrives at a hospital, is not taken into consideration. Does an 85-year-old man that needs a hernia operation, require the same level of care as a 65-year-old man who requires a hernia operation? How can we refine the system so that we can better address the issue of severity of illnesses? And I hope that today's testimony will uncover problems within the payment system and provide meaningful solutions to correct the inequities in the payment system, in order to maintain the highest quality of care.

Again, thank you, Jim, for convening the hearing. I look forward to hearing from the witnesses.

Mr. KOLBE. Thank you, John.

I am going to begin by introducing our first panel, who are seated up here at the front. We have four individuals: Vivian Soash and Ula Sabisch, senior citizens who have had experience with the Medicare system and DRG's.

We also have Otto Dworsky, who is representing the National Association of Retired Federal Employees, and Fran Smith, who represents the American Association of Retired Persons, and is on their national board.

We will begin by hearing from Mrs. Vivian Soash.

PANEL ONE, CONSISTING OF VIVIAN SOASH, RESIDENT, STATE OF ARIZONA; ULA SABISCH, RESIDENT, STATE OF ARIZONA; OTTO F. DWORSKY, PRESIDENT, ARIZONA FEDERATION OF CHAPTERS, NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES; AND FRANCES SMITH, AMERICAN ASSOCIATION OF RETIRED PERSONS

STATEMENT OF VIVIAN SOASH

Mrs. SOASH. Thank you. Please let me know if this is not quite right. I am not on medication, because this is my first day out driving, and when I drive, you do not drive on medication.

Am I being heard correctly?

Mr. KOLBE. Yes. I think so.

Mrs. SOASH. All right.

Touching on what Congressman McCain just spoke about, it is so important that we people give our evidence to these politicians. Whether you hate them or love them, they can do nothing alone.

I am a former Delawarian. That is a little State near Washington, DC, and Philadelphia. And I moved here 6½ years ago. I represent people from Green Valley, which is 25 miles south. I love it here, but my house is having to go for sale, because of an injury caused by two sheriff's deputies on August 1. I have had three surgeries since then. I face amputation. We are waiting to find out.

First, I am going to say I am not going to read some notes someone gave me, because I am not able to get up here often enough. And I told the person by phone they could give me some notes, but she has assured me I may be adlibbed.

Do get a living will, and do send it to your doctor. And do give your sons and daughters, especially if you are a two-family, like I am. That is something for all of you, positive, I hope. Pardon me, it is not on your subject.

All of these things that Congressman Kolbe has said, they have all been in the local papers. I just have Xeroxes. Everything about Medicare, fees, hospitals share the blame for discharging patients too soon, I will tell you in a moment.

Efforts to cut hospital stays costs, home, OK. Sending hospital patients home early brings unforeseen costs. I will explain this in a moment.

Medical costs rising faster than incomes. Now, a lot of you are not—I am on Medicare, just barely. I mean, you know, just barely, but I have never realized until this year, and I have determined that while I am caring for an 81-year-old semisenile husband, that I must use some of my energy. And I only have 6 hours a day to help in, anyway. I can at Green Valley, if nowhere else, and by that, I hope everywhere, because there are too few people in a much older age group, I do not mean—I mean in Green Valley, who have become afraid, who cannot talk any longer, whose voices—emphysema, whatever—cannot express themselves, or are afraid someone will do something to them about it. I am not. You can do anything you want, because, and I am quoting from the Arizona Star, and I only brought this to show you that this has been kept on hand and then—am I near enough to the mike?

Mr. KOLBE. You might move a little bit closer.

Mrs. SOASH. All right.

You see that I am a crisis patient. This is a medical caduceus. Those of you who do not know what a caduceus is, ask somebody, OK? I don't want to waste my time.

This says, "cardiovascular, see wallet." In my wallet, I carry a complete set, because if I am caught on the road, away by myself—I travel East sometimes, alone; I travel to Kansas to a daughter, alone, everything is in here, because no paramedic is to do what they are told to do. They are told to do what this says. "Don't intubate this patient." You will have a blood clot in the head or the lung, or something. I hope it is not my head, because they can keep you alive a long time. That is why your medical will is so important, if you do not want to have your income for your spouse used up to take care of you as a vegetable, OK?

Now, I have come out of the hospital. This is a testimony and the person who gave it to me, at my request, because I knew I would be late driving here. This is my first opportunity to be out. And I brought with me a copy. This is a copy; anyone who needs to may examine it. It refers to what is written here, and I have been given permission not to read it exactly, and in the interest of time.

I was injured on August 1, in front of my own home, due to two sheriff's deputies' negligence. This is another case; this has nothing to do with today, but it is why this is here.

I also cannot keep this on all the time, because I have had four cervical discs removed 18 years ago, when I was totally paralyzed. So I have, in between, been in wonderful hospitals. One of the best is Good Samaritan, the very best that I can name. I do not mean to be too partial, but I have been in a lot; Johns Hopkins, and others, and I have never been in a finer one or had a finer neurosurgeon than I had there. He did a disc chemo nucleolosis. Now, that is why I do not have to use my walkers and my canes any more.

The minute that gets done, and my husband needs constant supervision, this happens. Now, whether they amputate, or not, I can no longer keep my home, which was my only hope. My goal was to keep my husband, whose mother and brother both died in homes, one at 101, and 96, the other, after 15 years of senility and knowing nobody.

I promised my husband 18 years ago when I married him—and I am his third wife—that he would never end up in that situation, because as long as I could, I would take care of him. And that my company—or his company, pardon me—I am going to be rather specific, DuPont. I am getting—wave at me if I get near, but anyway, that we will stay where we are.

Now circumstances are making this impossible. I cannot maintain the small home that we have. We went into a small home.

Let me read a little. After this happened, I was taken to the local clinic, and a wonderful doctor there, I am not naming names, sent me immediately to St. Mary's Hospital to an orthopedist, who has since been dismissed, and whose name, again, is not going to be given, and has treated me three times. I have yet to know him. I would not know him if I fell over him. Now, remember, I am under anesthesia when he is operating. He does not come in until afterward.

I was sent—the first night, they didn't take care of me for several hours. They said, "Oh, a broken wrist; nothing to it." Well, they

found out, instead, it was a whole forearm, the wrist and every bone and everything in it. I cannot give you all the names. There are pins in here and a few more things—second, third surgeries, and more coming up.

So I was sent to Northwest Hospital. I said, "Where is Northwest?" Carondelet Services, which I just joined recently, takes care of St. Joseph's and St. Mary's Hospitals. And I just happened to think that your Catholic Nursing System is one of the best in the world. I am not Catholic, but I just think they are terrific. So, they tell me, "Well, Northwest does not have enough patients; we are being asked to send people to Northwest." I am being very frank, but I have documentation.

It should not have been billed. It got in under the certificate of need.

Mr. KOLBE. Can we stick to the—we want to hear your story, here, but in the interest of time, if you——

Mrs. SOASH. Right. I told you. I agree.

Mr. KOLBE. Mrs. Soash and I had discussed this before, that I would need to keep her to our topic here. We do have limited time.

Go ahead. We would like to hear what happened to you in the system.

Mrs. SOASH. Fine. All right.

In the system, in Northwest Hospital, I was sent there once, and given instructions by the doctor's office, which did not include that I must have a driver.

I have had many, many outpatient admissions at TMC, under a fine anaslethol—anesthesiologist. You wait in the recovery room. When the time is right, under their medical supervision, you go home.

This time, I go up, I go through all their blood takings, the EKG's, all this, and then they say, "Where is your driver?" and I said, "I do not have one. I am here." "Oh, we do not have a recovery room. We are economizing—no recovery room." Well, no one told me this. So, you go home. I get dressed. I go home. Then they set me up for the following Saturday morning. Do not ask me why, Saturday, Mr. Kolbe. I do not know what is going on. I believe there is a cut rate on Saturday, but that is my own opinion.

Now, we get to the point of the following Saturday, August 10. This happened August 1. August 3, I am there, and I go home. August 10, I take a driver, a lady who has been through plenty. She is waiting for me. I am picking up my notes now. On the 10th, a friend took me to Northwest.

I am going to read it; it is quicker. Surgery was performed. However, I did not put this in, or someone did not. When the anesthesiologist walked into the room, I said, "Please leave." He smelled. And I am sorry for you smokers.

I cannot be around smoke. I have had a growth removed, and I cannot get oxygen to the brain if there is enough smoke in the room. I moved here to get away from the East where you are closed in. I appreciate you smokers, but I said, "Get away." He stunk. In fact, I think I said that. I said, "You stink. I am under some sedation." He had a fit.

My doctor comes in, who is assisting. He said, "Would you please leave the room?" to this other doctor. "Take a bath, shower, sham-

poo, everything." I do not know what happened next because then they put me down deep. They put me down so deep that, instead of being an outpatient, I became an inpatient.

Now, this batch of records that I have here tells everything about my anesthesia. I have had cardiac arrest, respiratory failures. I have been reported dead twice from the ICU. With all that information, it doesn't mean a thing, because the specialist did not read it. So I find that these problems—the surgery was performed. However, I was not satisfied with the care I received at Northwest, and if anyone is here, I have been trying to get an interview with the CEO of Northwest for 3 weeks, and as late as 2 days ago, I was still told that he was busy or not in. So, I have had no chance to talk with him first.

I have a serious blood and respiratory problem complicating any surgery. That is why the I.D. These problems were not taken into account.

After surgery, evidentally—I do not know this, but this is what I am told—I was admitted to a room. I never had a clean gown on. The surgery gown I had on was all I had on through Monday, when a nurse finally came into my room. In the meantime, I had two male—I believe they call them aides—there were no name tags. They were kind, however. One of them—I was IV'd, and I was monitored with blood pressure. I did not know where I was. I woke up in the middle of some night—I guess, Saturday, and I do not know where I am. I have never been in a hospital, frankly, that did not check on a patient in a room, alone.

Mr. KOLBE. Mrs. Soash, can I interrupt? In looking at your testimony, you talked about the problems you had after you were discharged. Can you—you were in the hospital for 5 days, is that correct?

Mrs. SOASH. No; 3 days.

Mr. KOLBE. Three days.

Mrs. SOASH. I wanted to stay longer.

Mr. KOLBE. You said that you could not perform many of your normal tasks?

Mrs. SOASH. Right. I objected to being dismissed when the first woman I saw on Monday, the 12th, was a nurse, and she comes in and says, "You are discharged." I said, "Oh, no." I could not move. I could not sit up. I was weak from loss of blood.

She said, "Well, you will have to sign." I said, "No, but the physician has not signed." This is it. She says, "oh, no, he does not come in but on Saturdays." I said, "Well, I'm sorry, I will not sign myself out. If something goes wrong, I am responsible." She said, "Who can you talk to?" You know, get a lawyer. I said, "No; I do not want a lawyer." I have a son who is one.

So finally, she said, "What about a patient advocate?" Wonderful. So they called the Patient Advocate, a young man who really does not know what to do.

So, finally, I suggested that I would sign my dismissal sheet, which I did, but it is missing from here. They took the carbon out on me. I signed it under protest with his initials. He finally agreed that he would do this, but I did not see the bottom part. It was folded in half.

I assume I am going to have nursing care of some sort. I still have a catheter and blood—whatever you call these things out here.

Mr. KOLBE. Had you seen your physician since the surgery at this point?

Mrs. SOASH. No, no. I saw no doctor whatsoever.

Mr. KOLBE. Did anybody discuss with you what you were going to do when you got home?

Mrs. SOASH. It says, do as told. Here it is.

Mr. KOLBE. Had you asked anybody? Had you made any arrangements to talk to anybody about your care when you got out of the hospital?

Mrs. SOASH. I had not made arrangements. But you can bet a dollar, when I got home and found blood running over, I called my very fine general practitioner in Green Valley, and he said, "Get down, or I will send for you, immediately. No way should you be home with a catheter and the blood and all."

They had put pins in the arms, stitches all over, everywhere, and the danger of it having stuck to something over a certain period of time—you medical people may understand this—is critical.

Mr. KOLBE. Mrs. Soash, can I suggest that we are going to hear another individual with a similar story, and then we can come back and have questions in general on this whole thing, because I think this is—there will be some questions on this.

Mrs. SOASH. Fine, fine. Thank you. Thank you.

[The prepared statement of Mrs. Soash follows:]

PREPARED STATEMENT OF VIVIAN G. SOASH

While cutting up a fallen sahuaro in my front yard on August 1, 1985 I fell fracturing my arm and cutting my fingers. Neighbors found me and took me to the clinic in Green Valley. From there I was taken by ambulance to St. Mary's Hospital emergency care. There a physician worked on setting my arm, but said I would probably need surgery. I asked to be checked into the hospital because I did not have a ride home. The physician told me I could not be admitted for a broken arm; he added that he planned to operate the following Saturday, August 3 in outpatient surgery at Northwest Hospital. I was finally able to reach some neighbors and they drove in from Green Valley to get me.

On Saturday I went in to Northwest Hospital as directed. I drove myself. When I arrived, the head nurse, a Mr. Brown, told me they had no recovery room there and I would have to be driven home afterwards. I had not been told this before. Because I had no one to drive me home, I was then sent home. At the time I had 104 degree fever, and my arm still had sahuaro spines, etc. stuck in it.

On Monday, August 5, I called and was rescheduled for surgery at Northwest on August 10. On August 10, a friend of mine took me in to Northwest Hospital. The surgery was performed. However, I was not satisfied with the care I received at Northwest. I have serious blood and respiratory problems which complicate any surgery. These problems did not seem to be taken into account. Further, my postoperative care left a lot to be desired. After surgery I was admitted to a room after surgery but was not given a clean hospital gown, a bedpan, or instructed how to use the call bell. The blood was not cleaned off me, nor was the bed cleaned after I soiled it. The reason by the nurse's aide was that as a male, he was not allowed to touch a female patient, and that there were no nurses on duty. I should add that I was getting no pain medication though I was hurting badly, that my physician did not come to see me after surgery, and that my friend who drove me was never informed of my progress or location—she finally went home after being told I had been taken to a room.

On Monday, August 12 a Nurse Wimmer came in with a discharge sheet. I refused to sign to because I had not yet seen my surgeon. At the bottom of the discharge sheet they had checked "patient sent home". I explained that I had no one at home to care for me, and that I needed to stay in the hospital and have nursing

care. I finally said I would sign under protest and with Nurse Wimmer as a witness. I did so, and left the hospital with a couple from Green Valley who were there to drive me home.

From the time I went home that day until the present, I have had no in-home nursing care. Because of complications to my circulatory system from my respiratory and blood problems, I ordinarily have the use of only five fingers. Between these permanent problems, with with I have learned to manage, and the cast on my arm, I have been unable to perform many necessary daily tasks for myself. I have been unable to bathe. I have had to change the bed linens with my teeth. It has been very difficult to prepare food. In addition, I am solely responsible for the care of my husband who is senile and incapacitated much of the time. Ironically, on my discharge sheet, it was noted that I would probably need assistance bathing, that I would not be immediately ambulatory, and that I should not lift things. Yet surgical hospital staff were, or should have been, enough aware of my physical problems and lack of in-home assistance that they should have realized how very difficult it would be for me to care for myself after leaving the hospital.

After leaving Northwest Hospital I have had several visits to my doctor in Green Valley—to take out the catheter, to change my cast, etc. I am still not recovered, and I am still experiencing all the difficulties I have described.

Mr. KOLBE. I would like to go and ask Mrs. Sabisch—which way is it, Sabisch?

Mrs. SABISCH. Sabisch.

Mr. KOLBE. Sabisch—OK, just as it is said. Mrs. Sabisch, if you would go ahead, and give us your testimony.

STATEMENT OF ULA SABISCH

Mrs. SABISCH. There have been four times in the last——

Mr. KOLBE. Would you get those microphones as close as possible to you?

Mrs. SABISCH. There have been four times in the last 2 years when I think I was discharged from the hospital too early. In each case, after I returned home, I still had complications, and needed a lot of assistance and nursing care.

With the help of home health nurses from Medical Personnel Pool, my daughter, Keitha Zimmerman, has been able to care for me. I am very thankful for this. Without the Medical Personnel Pool, we would have been sunk. But I think I needed to stay in the hospital longer in each case, and receive expert care and attention.

In late November 1984, I developed a diabetic ulcer on my foot. I was treated for this as an outpatient, and it did not heal.

In late December, I was put in the hospital at Tuscon General for this, and after that, I was an outpatient at St. Mary's Burn Center from January 30 to April 15. I went every day, 7 days a week, to have this treated. This created a tremendous burden for me and my daughter.

On April 16, I went to the hospital with congestive heart failure and pulmonary bronchitis. I stayed for 5 days, and then was sent home because I had stayed the limit for pulmonary bronchitis.

After I came home, my daughter had to give me treatments four times a day. The home health nurse came out there three times a week.

On June 17, I was in the hospital again for a mastectomy, followed by chemotherapy. They did the mastectomy and pulled some lymph nodes out, but they could not do a radical mastectomy because they could not hold me under the anesthetic long enough.

I was so sick when I came home. I am still having chemotherapy.

On the third day after surgery, the day I was to leave the hospital, when I was getting dressed, my wound opened and blood came and went all over. They decided I needed to stay another day in the hospital.

Just recently, my wound reopened, and my daughter had to take care of it.

I just spent 16 days, from August 9 to August 26, with a staph infection. I was still on an IV when I came home. I had to have 30 ccs of bactrum given through an IV twice a day, at a cost of $65 per day, and I had to pay that myself.

The home health nurse came to my home twice a day to administer that, but it was very hard, due to deflated veins. I am a diabetic. And finally, it came out. And my daughter had to take me to the doctor so that the dose could be given. Without home health care, I would have been up a creek, or I would have had to go over to the hospital twice a day for the IV.

Because I am a diabetic, I have heart problems, and have a pacemaker. And I also suffer from arthritis. There have been many complications each time I have been in the hospital.

I do not think I would have been able to survive without the hospital, without the attention and help of home health nurses, and the round-the-clock dedication of my daughters. I have two daughters that help me.

Mr. KOLBE. Thank you very much, Mrs. Sabisch. We will come back to you with some questions, shortly.

Otto Dworsky, representing the National Association of Retired Federal Employees. Otto, thank you for being with us today.

STATEMENT OF OTTO F. DWORSKY

Mr. DWORSKY. Thank you, Congressman.

My oral testimony will be entirely different.

When I was the service officer for the National Association of Federal Employees in Arizona, I investigated probably 20 to 25 cases of overcharges and other care problems.

Talking to individuals, most of them, they agreed that the health care was excellent, and the hospitalization was very good. The only thing is the exorbitant prices.

Under Medicare, Medicare covers only 80 percent, I understand. I have talked to hospital administrators throughout the State, with bills that had been presented to me for overcharges.

We will take one example of a bill that is overcharged on aspirin. It costs $1 to the patient in the hospital. The administrator says the reason why this price is so high is that it goes through so many hands before it gets to the patient.

I have taken a look at charts, medical charts, that doctors have gone ahead and authorized painkillers, and the patient does not take the painkillers. They are still charged for it, throughout the State of Arizona, and 20 hospitals that I have checked.

I have asked the administrator why does this occur. The administrator says because it's too much trouble to return the medication to the pharmacy. So they throw it away, and you are charged for it.

Also, I understand that next year—and Congressman, you can correct me on that, that Medicare deductions are going up to $600. This is going to be difficult for people on fixed incomes, Social Security, and Federal retirees, which Peter Gray says are overpaid. And I think Peter Gray should get ahold of these hospitals, and find out, and investigate the charge problems.

Also, on nursing care, I have investigated three cases that were supposed to have a special nurse for intensive care. The nurse is only there, I would say, roughly, only one-third of the time, and the patient is being charged for a full-time intensive care nurse.

Medicare does not cover the following items: Cancer: radiation, chemotherapy; surgery: amputation, heart transplants; heart surgery; dental, eyes; arthritis. These are the items that are not covered by Medicare, or any insurance agency.

I have talked to a number of insurance agencies, and if you do not have an insurance policy while you are young, and keep it up after you are 60 to 65, or 70, you cannot receive an insurance policy for these coverages. And the price is exorbitant.

I have also talked to some doctors throughout my investigation in the State of Arizona. The doctors and the patients tell me that their care by the doctors is excellent most of the time. I have never had a complaint that there was a malpractice suit.

The only complaints that I have received are that the charges are too high. The test that is given to the patient, 80 percent of the time, the doctor does not know what it costs. This makes the bill to the individual exorbitant, and also to the insurance company.

In my opinion, Medicare health care is very good. The only thing is, is that Medicare does not pay enough for the fixed income.

I have received letters from elderly, 85- and 90-year olds, asking what could I do about the prices, because they can no longer get out and work and pay for their medicine for their medical treatment. One individual in Green Valley, who is 73 years old, is going out to pay for his chemotherapy working at $5 an hour. Thank you.

[The prepared statement of Mr. Dworsky follows:]

PREPARED STATEMENT OF OTTO F. DWORSKY

Answering the questions in numerical order:

1. a. From all the individuals that I have talked to, the health care is excellent for hospitalization, but the costs are exorbitant, and Medicare does not cover it. In addition, Medicare is going to increase their deduction to $600.00, and an individual on fixed income will be between a rock and a hard place to pay for it. Medicare is very slow in reimbursing the hospitals, and hospitals are constantly harassing the patient for money. Something should be done in this area for expediting payments. Physicians services: I have not been able to find any discrepancies in the physician services to the elderly; the only difficulty is that the physicians are very expensive and Medicare does not cover the medical expenses.

b. Medicare services do not cover enough payment on the following: Cancer (chemotherapy, radiation, prosthesis, surgery, amputation), transplants, heart surgery, dental, eyes, arthritis, and diabetes.

2. a. Some people say that they were discharged too soon and some say they were in the hospital too long, and could have been discharged earlier to save money. This is a hard question for NARFE to answer, as each person has a different view.

b. At this point, I do not know of any particular recommendation being made; however, it could be discussed among all of the NARFE members at meetings over the state, and the results forwarded to your office if you so desire.

3. a. i. In small towns, very few services are available; L.P.N.'s, or registered nurses, or Public health nurse visit once or twice a week. (Public health nurse charges a fee); ii. Paid for out of their own pocket; iii. I have no figures on this.

b. In Cochise County, we have the Cochise Aging Service, Bisbee, or private R.N.'s or L.P.N.'s. Cochise Aging is very inadequate and very prejudiced as to home care. L.P.N.'s are too costly and so are private R.N.'s.

4. Under Medicare, I feel that the health care service is very good, but does not pay enough of the costs for people on fixed income. Only the doctors can control the price. It is my opinion, and that of some others, that each patient (individual) should only pay the Medicare deductible, and doctors, hospitals, etc., should accept what Medicare pays as full payment.

No other charges should be presented to the patient or individual.

Example: Car insurance: if your car is "hospitalized" because of an accident, you have a deduction of your choice: $50.00, $100.00, or $500.00, and if you have one of these deductions, this is what you pay for the entire accident.

Mr. KOLBE. Thank you very much, Otto.

Mrs. SOASH. Sir, could he have just said of the reasonable and customary charges—which is what it is—not 80 percent of what the doctor charges.

Mr. KOLBE. Let us go and finish up the testimony from our panel, and we will come back to specific questions here.

Fran Smith of the American Association of Retired Persons. And, Fran, we are glad to have you out of the hospital, and here with us, today.

Ms. SMITH. You know what? I am glad to be here, after hearing some of this.

Mr. KOLBE. I bet you are.

Ms. SMITH. In fact, I'm a little dancy in the head; a little unstable on the feet, but I consider that nothing after what I've been hearing. So I'm very grateful to be here with you.

STATEMENT OF FRANCES SMITH

Ms. SMITH. I would say, too, that as a member of the American Association of Retired Persons, AARP, we have been very much involved in a nationwide program, Cutting the Costs and Keeping the Care, and this is still continuing.

I think my testimony may be a little bit different, although I may get into some of the personal.

We definitely have a very great interest in the impact on the diagnosis-related groups, the DRG's, as they are so-called. But we cannot consider that, alone, and I know you are going to hear some more of this later, without considering the Peer Review Organization and the Prospective Payment System. I did learn something about the Prospective Payment System and the DRG's from a very personal experience, recently, and it will come into play with the comment I just made.

It does not matter how much your bill is, or whether you have been overcharged on the DRG's, Medicare will pay what is allowed by that classification under the DRG's.

I went over my bills. I have been in this institution, and I had beautiful care. I cannot complain. I was in here twice within the last month. It does not matter that on that bill, was an item for which I was charged. It was $12 and something. I never received that item. I was charged for something that—apparently I slept on one of those popcorn or egg-crate things, and I couldn't stand it. They ripped it off, and I left it there. And I thought, well, if I paid for it, perhaps I could use it, or give it to somebody who might use it. I do not want it, but it does not matter what your bill is, wheth-

er you are overcharged or not. Medicare is only going to pay that hospital so much.

That is one of the clauses of the DRG's, very definitely. There is no flexibility in this, the DRG systems. It very definitely needs to be reviewed and modified, as I am sure it will be, by Congress. Am I right? It is being considered, now, in the Senate, is it not?

Mr. KOLBE. Indeed.

Ms. SMITH. When hospital costs came about, the DRG's were developed. They were constructed principally by hospital administrators and some physicians and clinical consultants, as I recall. There was no input at all from a great many physicians. There was no input at all from nurses. There was no input from the beneficiaries, and this is something that Congress should consider.

We need to broaden—and this is a recommendation—we need to broaden the participation, when the DRG's are being reconsidered, or modified, or whatever you care to call it, or classified. The beneficiaries have a different perspective, for example, about being discharged early. The nurses have a different perspective about the needs of the patient. The physician has a different perspective, and these need to be brought into focus, so that some reality can be brought into the Medicare payments, the prospective payments. Presently, I do not see it.

Presently, I see a great many things happening. These were numbers when these DRG's were established. We had numbers. We had averages, and those were translated into dollars, and to heck with the patient.

The patient had no consideration in this. There was no consideration beyond, let us say, the length of stay for the patient. There was no consideration for the severity of illness, again, which requires different perspectives from different groups, from the nurses, from the beneficiaries, and so on, from the physician. None of these was considered in this, and they must be considered when they are to be modified.

I see conflicts developing with the DRG's. I see conflicts, for example, between the hospital and the doctor. We had an example with this. The doctor says, "You may be discharged as of today." Fine, no problem, if you are able to care for yourself. If you are not able to care for yourself, where do you go? A nursing home is no longer covered by Medicare. Home? There is no one there to look after you. Home Care Services certainly are not developed to any great degree in this community. So, what do you do? I have often said, "Sometimes, it is cheaper to die." It really is. And cremation does not cost too much.

Is that what it is now? Cremation, she said, was how much? $345. It used to be $250 when I was thinking about it.

We have conflicts. For example, the doctor may say, "The patient needs to stay longer." The hospital says, "Well, that's tough, kid. We are losing money if we keep that patient here beyond this length of time, the DRG." So, you have a conflict developing there.

You have a conflict between the patient and your physician. The physician realizes what's happening. The patient feels he needs to stay there. So, you have conflicts there, and all of this bears on what I consider the quality of care. It is very hard to define.

I had beautiful quality of care in this hospital last month. And that quality of care consumed a great many of the hospital's resources—and this I know—a great many of them. The hospital, fortunately, I think I was within the length of time of the DRG both times. So, it may not have to be eating the extra loss. I am hoping it does not. These things can affect the quality of care, and I think this is extremely important.

If the hospital wants to make a profit, it cannot consume all of the resources as it probably would under normal circumstances. Somewhere, there has to be some conservation going on.

I had, on my bill and I am sorry I did not bring both of those bills; I didn't know we were going to get into this kind of personal thing—I had on there, at least a half of page of supplies. I might tell you that the President and I had very much in common, only mine was a little more complicated. I think I'm a year older than he is.

I can see, for example, where these early discharges as I mentioned, people having no place to go. They find themselves back in the hospital. By word of mouth, in this area, I have heard of two instances where the patients were dismissed early, needed to return to the hospital, but before that happened, they died. Now, you cannot pin this down and say that it was because of early discharge. I cannot, for example, having been out of this hospital for—I don't know—maybe a week or less, and having to return, I cannot honestly say that this was a result of early discharge.

So, there are all these little questions that have to be faced in relation to the DRG's. There is no question about it. And I do see them affecting the quality of care, eventually, through the conflicts that are to develop, and these things must be addressed. They need to be modified, reclassified, if you will. They are weighted. There is a relative value here that is attached to them, and they need to be looked at from the standpoint, as I say, as to what the cost, according to the DRG, and what Medicare will pay, or should pay. It is probably the proper word—should pay.

The physician's practice patterns—now, the DRG's are supposed to have some control over physicians. I think maybe the Congress may have to look beyond this a little bit because I am not sure that the physicians are going to lie down and play dead. And I am not sure that they should. I think there can be a method developed whereby the physicians can control costs.

One of the things that happened to me, and again, bring in the personal, is because my chest was so congested when I first came in for the first operation, they had me on oxygen, and a few other things. The oxygen, in the second go-round, which had nothing to do with my lungs—my lungs are as clear as can be through my good living now. In my room, they had oxygen daily and daily it was checked and daily, it was never used. But I was charged. Now, I am not saying that because that oxygen was in the room, that I should not be charged something. I was utilizing that particular item, but I am saying that the physician should have been aware that I was not using it, and should have removed it. And it should not have been on the bill. But it was. But Medicare will not pay for it, according to the DRG.

One of the items that was mentioned at the table was about cost. I would tell you that, in the teaching hospitals, and I think this is true also in the university hospitals, that they, the interns, are now being taught something about costs—tests, costs of tests, costs of oxygen use, maybe, bandages, resources of the hospital, and those claimed by the patient.

I would also inform this gentleman over here that there is insurance available for people past 65. You have to pay $5 to join AARP, and then you can buy your insurance.

Mr. KOLBE. Fran, can we get you to conclude, so we can get some questions in?

Ms. SMITH. All right.

There is no custodial care covered by any insurance that we can find out. However, I would tell you that there is something in the works that has been started here, locally, and hopefully, it may eventually develop into something that we can afford, for custodial care.

I think the public needs some education, Congressman, and it is either going to have to come through Congress, or it is going to have to come through HCFA, Health Care Financing Administration, or it is going to have to come through Medicare. It is going to have to come through somewhere. We are doing our part through the association, but we cannot reach everybody. And I think the public needs some education regarding not only Medicare, but how these DRG's impact on their welfare.

And I thank you for this opportunity, and I will keep still for questions.

Mr. KOLBE. Thank you, Fran. Very much. You couldn't have concluded that first panel on a better note.

That is exactly why we are holding this hearing. It is that one of the very primary reasons for this hearing is for the public to gain some information about this system and how it works.

Ms. SMITH. I would like to ask, Congressman Kolbe, how many in this audience really understand the DRG's? How many do not understand it?

Mr. KOLBE. I am sure all of us have to learn a lot, but we have different problems.

Ms. SMITH. And are you honest in your evaluation of this subject?

Mr. KOLBE. Thank you, Fran.

Let us go and take some questions. I would like to begin with my colleague, John McCain. John?

Mr. MCCAIN. Thank you, Mr. Chairman.

I regret that we do not have more time to hear from this panel. I believe it is important to begin the hearing by listening to testimony presented by those who are directly affected by DRG's.

I will be interested, Fran, in hearing from Dr. Duncan, whether there was input from beneficiaries when formulating DRG's. And we will give them time to respond, or defend themselves, as the case may be.

I am told that the 1983 legislation does call for a study as to determine whether physicians should be included in the DRG payment system. And we are expecting that report out. It was due in July, so we should receive it soon.

Ms. SMITH. May I suggest another alternative be considered? And that might be the relative value scale, the fee for services, but according to certain criteria. Give it some thought, instead of the DRG's.

Mr. MCCAIN. Also, later, we will discuss an area that this panel did not address. And that is the problems that physicians face with the escalating costs of malpractice insurance. Many claim this to be a major contributing factor to high health care costs. I will be brief, Mr. Chairman.

I would like to ask Fran and Mr. Dworsky, what are your reactions to the stories that you've heard from the other two witnesses? Are they unusual? And do you know of other senior citizens that have experienced similar difficulties?

Mr. Dworsky, could we start with you?

Mr. DWORSKY. I know of about six cases that have the same problem as these two ladies, here. Since they brought it up, and I did not want to bring it up in my oral testimony, I could have invited one individual that is 80 years old. And he is screaming for help, saying that he doesn't get any treatment. And it falls into about the same category as these two ladies here.

Mr. MCCAIN. Thank you.

Fran?

Mr. KOLBE. Would you get closer to the mike? Thank you.

Ms. SMITH. I tried very hard to find cases of this kind, and I heard of only two. And they were very indefinite. I did mention the two that I had heard, by word of mouth, who had died before they got back, but beyond that, I cannot comment.

Mr. MCCAIN. Thank you.

Mr. Chairman, in the interest of time, I have two final questions, and, again, I would like to state that it would beneficial to spend the entire morning with this panel. However, we must move along to our other expert panel.

My two questions are for Fran Smith and Mr. Dworsky.

Since the DRG system began its implementation in 1983, have you noticed an increase in complaints from members of your organizations?

The second question: Are there one or two areas that you feel are most important, to be addressed by Congress in its review of the DRG system?

Let me start with you, Mr. Dworsky.

Mr. DWORSKY. The Federal retirees, most of them are not under the DRG. They have their own insurance, such as Blue Cross, Blue Shield, Aetna, and other insurances. They only have a gap filler which NARF has for them to take if they wish to apply.

Mr. MCCAIN. Thank you.

Fran?

Mr. Dworsky, do you want to add to the second question, is there any area that you think needs to be addressed?

Mr. DWORSKY. I am not too familiar with the DRG's because I have never been in a position to investigate it or make any comments on it.

Mr. MCCAIN. Thank you.

Fran?

Ms. SMITH. Certainly, the AARP has had volumes submitted to them on cases on a nationwide basis. I talked with them, yesterday, and they have had no referrals, really, from Arizona. Now, I think probably this comes from the fact that we do not know where to make our complaints.

If we have a complaint, to whom do we complain? I understand that the PRO Advisory Committee is being set up and that is fine. But everybody must know about this, and who is on it. The PRO—Peer Review Organization—which is kind of the watchdog of the DRG system, I would say, who is on it? Where is it? Well, it is probably in Phoenix. I do not know where it is.

So, definitely, the association has volumes of material that has been submitted nationwide about cases that have been dismissed early, and problems.

The two areas that I would say, statewide, that may be needing the attention, is a little more money for home care, extending the services. And the other is nursing homes.

If you do not belong in a skilled nursing home, and you have to go to the nursing home, and there is no Medicare for the nursing home, you are digging into your life savings, probably before you get out of there. And then there is another group that does not belong in a skilled nursing home, and they do not belong in a hospital. So, where do they? So, these are areas that I feel need special attention.

Mr. MCCAIN. Thank you, Mr. Chairman.

Ms. SMITH. That is, more money.

Mr. KOLBE. Fran, thank you.

Your comments that you made earlier about the possibility that it should be considered by Congress of paying on the basis of a fixed fee, essentially for——

Ms. SMITH. I mean that was a relative value scale.

Mr. KOLBE. Relative value scale. That is being considered, but not for hospital payments, but for physician payments.

Ms. SMITH. For physicians.

Mr. KOLBE. Is that what you were directing?

Ms. SMITH. That is what I am directing. And it would be a fee for service, and it could be based on different criteria. One might be, how much time do you spend with this patient? Another might be, how much experience have you had?

For example, a fellow that is just out of training, a young doctor, might—well he could expand his time, but he would not necessarily have all the experience that he would need.

So some of these factors need to be considered, weighted, and other things that might fit into that relative value scale, a fee for services.

Mr. KOLBE. Do both of your organizations, either Otto or Fran, have an extensive program of trying to tell your members about the DRG system and how it works, and how the whole Medicare system works?

Ms. SMITH. Congressman Kolbe, we have covered the States from Alaska to Hawaii.

Mr. KOLBE. Through mailings to your members?

Ms. SMITH. We have done everything we can. We have been in meetings. We have literature. We have——

Mr. KOLBE. I take it, though, Fran, from what you said, one of the things that is not covered, is the peer review organization—where it is located, how to get those complaints made. I gather there is no information given at the hospital about how you can make a complaint?

Ms. SMITH. The hospital is a little reluctant to give any information.

There is no feedback on this.

Mr. KOLBE. So that might be a component that you would want to include?

Ms. SMITH. We do know that there is a peer review organization in this State.

Mr. KOLBE. Yes, there is. You will hear something on it.

Ms. SMITH. There is a gentleman from Green Valley who has been participating ex officio, from the AARP Association, on it.

VOICE. Could you name him? I have never heard of that.

Ms. SMITH. I will tell you.

I honestly—I do not know where the peer review is located. Is it in the health services, in Phoenix? Where is it?

Congressman McCain, do you know? You are from Phoenix?

Mr. MCCAIN. Fran, I thought we were friends.

Ms. SMITH. Where is Deborah Nixon?

Mr. KOLBE. I know what it is. We will come to that question. I know that it is a part that is funded by Medicare, and where they are physically located, I do not know. But we have somebody here on that. And we will come to this question of peer review organizations.

Ms. SMITH. But we cannot educate people as to where it is, until somebody knows where it is.

Mr. KOLBE. I think we will be able to address that on our next panel.

Everything is being taped, Catherine.

I would like to ask a question of Ms. Sabisch and Ms. Soash.

Ms. Sabisch said that she did get home health care.

Was any consideration—did you receive any home health care services in Green Valley, Mrs. Soash?

Mrs. SOASH. I did not. I told them I did not want to leave the hospital, because I have a senile husband at home. I take care of our home, completely, indoors and outdoors. And that I signed only under protest because they had called two people from Green Valley to bring me home.

Mr. KOLBE. But did anybody advise you whether any home health care services were available when you were discharged?

Mrs. SOASH. They told me the doctor did not order any and that I was to go. And I gave that gentleman that form, and it is marked. There are four places, and you see, it is marked "home," and you see above it, it says that I am supposed to bathe, but I will need assistance. And I said to them, "Who is going to help me?" I have not had a bath until last night, since August lst, and I took it because I was going to be in close contact with people.

But, in addition, I change my beds by using my teeth. I put my bottom sheets on, a stool under it. I am very strong. I use my teeth. I have never had a broken bone before.

Mr. KOLBE. So you did not have anybody that was coming in to assist?

Mrs. SOASH. I have nobody, still. I have no food service. I have nothing. I do not qualify for Meals on Wheels.

Mr. KOLBE. Was your general practitioner involved—did you consult him at any point before you were discharged or before you went for the first surgery?

Mrs. SOASH. By mutual agreement, after the third situation, the specialist has been dismissed, and my general practitioner, who is excellent, has assured me he is going to take this off next week.

Mr. KOLBE. He is in charge of your care?

Mrs. SOASH. They have taken one off, and put another one on, 27 pounds. So, if I fall over, that is why, but if there s a problem, he will have the best in the State. But he said, "You know, it is tough to get another specialist, when you have had to retire a specialist."

Mr. KOLBE. In both cases, let me ask, Mrs. Sabisch, do you think your physicians should have done a better job of keeping you informed of your illness and the problems you might experience?

Mrs. SABISCH. No. I have four, and they are very good.

Mr. KOLBE. And they have been very careful in telling you what——

Mrs. SABISCH. Yes.

Mr. KOLBE. OK.

I take it you have a different situation, Mrs. Soash?

Mrs. SOASH. May I say that even the surgical hospital staff were, or should have been, aware of my physical problems and lack of in-home assistance, and realize how difficult it was for me to go home. But they still sent me home. I had no choice.

I was delivered by wheelchair, against my wishes, by the patient advocate, and told to go home. And I believe there are people in the audience from, nurses, indeed, in Green Valley. I do not see them, but I understand there were some to visit here today, who can testify to the fact. That this is fact. I have documentation.

After leaving Northwest, my doctor immediately had me come to the office. I got a person across the street to remove the catheter, scared to death that it had adhered to some of the tissue or the pins, or whatever, and that I was going to have more complications.

I think that is frankly why the doctor did not sign my release that that gentleman over there has. Do you see the blank line? Do you see it, sir?

Mr. KOLBE. Yes; we have it.

Mrs. SOASH. Thank you, very much.

Mr. KOLBE. Thank you.

I want to thank this panel, again, for giving us some very good insights from very personal testimony of the problems they have had, individually and also in the case of two of them, with the problems that members of their organizations are experiencing with the Medicare health care system. I want to thank you all for participating in this panel.

Thank you very much for being with us.

Mr. KOLBE. We will start by introducing the second panel of witnesses today. It consists of Mr. Robert O'Connor, who is the region-

al administrator for the Health Care Financing Administration. Those of us that get into this lingo know it by its acronym, HCFA.

Second, Dr. Ted Koff, whom I have known for several years. I think this community is very fortunate to have somebody of his stature and expertise. He is one of the leading individuals in the country in gerontology research and care. He is the director of the Long-Term Gerontology Center at the University of Arizona Medical Center.

And, third, we have Dr. Don Duncan, who brings some special expertise in the development of the DRG system and the organization that he heads that had the HCFA contract for developing the DRG diagnostic groups.

We will begin by calling on Mr. O'Connor for his testimony. And I want to say to all three of the panelists, so that you can feel free to summarize your testimony, it will be printed in full in the record. That is just a suggestion in the interest of allowing us enough time to ask questions.

Mr. O'Connor.

PANEL TWO, CONSISTING OF ROBERT D. O'CONNOR, REGIONAL ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION; DR. THEODORE H. KOFF, DIRECTOR, LONG-TERM GERONTOLOGY CENTER, UNIVERSITY OF ARIZONA MEDICAL CENTER; DR. DONN DUNCAN, PRACTICING PHYSICIAN, STATE OF ARIZONA AND DR. LAWRENCE SHAPIRO, PEER REVIEW ORGANIZATION, STATE OF ARIZONA

STATEMENT OF ROBERT D. O'CONNOR

Mr. O'CONNOR. Thank you very much, Mr. Chairman.

I am particularly glad to have the opportunity to summarize my written testimony, and perhaps deviate from it somewhat, since these prepared comments could sound very strange, following the previous panel.

The things set forth in my written testimony are quite true. We do not have any evidence, that PPS is causing a decline in the quality of care. However, that would seem a very strange and cold thing to say in this setting.

I do not intend to say that people are not discharged prematurely, from hospitals. But I will point out that there are people who were discharged prematurely before PPS. The question is: Is PPS inducing any significant increase in the amount of premature discharges? That is a question that really needs to be addressed in this context, But it does not seem to have very much meaning, when you contrast it against one premature discharge which can be so tragic.

So, what I would like to do is explain how DRG's were supposed to work; how Congress thought they would work when they passed the legislation and how the administration hopes it is being administered.

First of all, as far as flexibility is concerned, the DRG system does not say that a particular patient with a particular diagnosis stays in the hospital *x* number of days, and that is that. That is not the system.

What the DRG system does is set a price that Medicare will pay for the hospitalization of a patient with a certain diagnosis and other characteristics. Now, it was recognized in developing the system that some patients were going to need more care than the average. It was also recognized that some were going to need less care than the average. It was expected that on the average, in general, the hospital would get a fair amount in return for its treatment. But it was also understood that there would be special cases, where a particular patient, because of special needs, or age, or various other factors, would have to stay in the hospital for a prolonged period of time.

So Congress provided—and it is part of the system—for extra payment in those cases. That is, either in a case where extraordinary sevices have to be provided beyond certain costs, or if the length of stay goes beyond certain limits, additional payments are available.

Second, aside from the patient himself, the physician is the one who decides when that patient is discharged from the hospital. Under this system, if the hospital cannot override the physician in the sense that it can arbitrarily discharge his patient. In order to declare the patient to be in the hospital for an excessive period of time, and therefore liable for any excess cost, the case would have to be submitted to the Professional Review Organization. Only if the PRO agreed with the hospital that the physician was wrong on the length of stay, would the patient become liable for that excess care. And on this score, I will point out that we have, in this room, the president and the executive director of the Arizona PRO, who I am sure would be willing to introduce themselves.

Mr. KOLBE. As a matter of fact, I have that card. I was going to do that when the three people finish testifying.

Mr. O'CONNOR. Oh. I'm sorry, Mr. Chairman.

Mr. KOLBE. That's all right.

Mr. O'CONNOR. Now, some of the other witnesses expressed puzzlement about where the DRG system came from. It arises in this way.

Since about 1970, the Congress and every administration that has been in Washington have believed that to stop the spiraling cost of hospital care in the United States, you had to go to prospective payment. DRG's are just a mechanism that allows that, because if you are going to set a prospective payment, you have to define what you are paying for. And that is all the DRG is. It is a way of defining the package of services that is being paid for in a hospital stay.

Where did it come from? It came from Yale University, under a study that was funded by the Health Care Financing Administration in 1974. Physicians undertook a lengthy study in which they attempted to divide all of the admissions in the hospitals into certain clinically meaningful groupings and then assess the relative cost of those particular groupings. That is all the DRG system—a system for classifying services.

What HCFA did was to take that information, and compare it with what it already knew about the costs of hospitals in the United States. It started with the cost that was actually being incurred by hospitals in the United States, and it used that average

as a guide. And then it adjusted for area wage differences, and a lot of technicalities. But basically, what it did was determine the cost being incurred by hospitals for each DRG and make prospective payments based on those amounts. It was hoped that this would give the hospital for the first time, an incentive to move people out of the hospital, when they no longer needed to be there.

Now, I understand that people may have no one to go home to and there may not be enough nursing homes. But a hospital, with its vast costs is not the place to keep people in order to meet their needs for food, shelter, and for basic maintenance care. Such an approach is so expensive that the United States of America cannot afford it. We demonstrated that we do not have money enough to do that.

So what do we need to do? We need to continue to refine this system and make it better. Sure, Let us add severity of services as soon as we can do the arithmetic and learn how to do it well. Sure, let us make all the refinements we can. But beyond that, what we need to do is develop new ways of helping aged people. Just as we started studying the DRG's, back in 1974, we have a number of demonstrations designed to find new ways of bringing together all of the resources—Meals on Wheels, and the other support programs—to bring them together to stand behind the health system, to find a way to meet the needs of the aged, without the back-breaking costs of trying to do so by inappropriate use of hospitals.

I hope this helps somewhat.

Thank you.

[Prepared statement of Mr. O'Connor follows:]

PREPARED STATEMENT OF ROBERT D. O'CONNOR, REGIONAL ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman, I am pleased to be here to discuss the prospective payment system (PPS) and its impact in Arizona. We share your interest in assuring that high quality medical care continues to be provided under the new payment system and want to describe our activities to accomplish this aim.

BACKGROUND ON MEDICARE

As you know, the Medicare program was enacted in 1965 to provide insurance coverage of hospital, physician, and other medical services for the elderly. This coverage was extended to disabled individuals in 1973. Almost 13 percent of all the people in the United States, or close to 31 million individuals, are covered by Medicare. This year Medicare will pay medical bills for over 20 million beneficiaries. In Arizona, 389,000 Medicare beneficiaries are served by 63 PPS hospitals. Over half a billion dollars were paid in benefits this year in all Arizona hospitals.

Medicare's PPS is probably the single most important improvement in the Medicare program since it began in 1966. For over 17 years, hospitals were reimbursed on a reasonable cost basis which failed to encourage efficiency since reimbursement is based on incurred costs. Under PPS, with the amount of payment set in advance and based primarily on the patient's diagnosis, hospitals which organize and provide services in an efficient and cost-effective manner are rewarded.

The new payment system is now nearing the end of the second year of a three-year phase-in from a combination of hospital-specific and regional rates to a fully national prospective rate. Congress provided the three year transition period in order to allow high cost hospitals time to change their behavior to live within the national rates. In Fiscal Year 1987, a fully national rate will be based solely on the national urban and rural averages. The urban and rural Federal rates are, of course, adjusted for differences in area wage levels.

Changes in hospital behavior to adjust to the new system have been positive. Reductions in length of stay have moderated the amount of resources needed to provide routine care. Arizona's average length of stay consistently remained below the

national average of ten days even before PPS. Since implementation of the program Arizona's average length of stay has continued to decline, now 7.14 days for fiscal year 1985 compared to a national average of 7.67 days for PPS hospitals.

It was believed that the prospective payment system would encourage earlier discharges from hospitals, probably to other types of care such as home health care. However, statistics from our monitoring of the system show that discharges from hospitals to home health agencies have increased less than one percent, from 2.9 percent at the beginning of the implementation of the system to 3.7 percent at present. We believe the availability of home health care in Arizona to be adequate to respond to this increase.

QUALITY AND ACCESS

One of our primary goals under PPS is to maintain quality of care. High quality hospital care has a long-standing tradition in this nation and our prospective payment system was developed with that commitment in mind. We have reason to believe that the prospective payment system may actually enhance the quality of care provided to Medicare beneficiaries. This system has the advantage of encouraging hospitals to specialize in those types of cases which they can treat efficiently and effectively. Most studies have shown that as hospitals specialize in providing services, the quality of care improves. This is because the performance of some procedures are enhanced by a high volume of cases which helps to maintain proficiency in treatment. These studies indicate that when certain services are provided in hospitals with low volume, quality of care tends to suffer.

When the PPS legislation was being debated by the Congress many believed that inherent to PPS is an incentive to admit patients to the hospital. Rather than being concerned about access to hospital services, opponents and proponents of PPS have worried that admissions would be excessive, thereby exposing Medicare beneficiaries to unwarranted risks. Fortunately, these concerns have not been justified. Medicare admissions under PPS have followed the downward trend in admissions for the non-Medicare population seen nationally over the last several years.

Working in partnership with PPS is the Peer Review Organization (PRO) program. In changing the incentives under which hospitals provide services, both Congress and the Administration were aware that medical review had to change from its historical form under the Professional Standards Review Organization program. The PRO Amendments in the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) set a firm foundation for this reduction. We believe the PRO program has enhanced peer review under Medicare by directing review activities specifically toward those quality, cost, and utilization areas most likely to be affected by PPS.

A major provision of the new PRO program is the use of measurable performance objectives both for admission and quality review. Through the use of these objectives in our contracts, PROs are required to accomplish goals they themselves set. This new approach is a vast improvement over what prevailed before and ensures that PROs will monitor actively the quality of care in their State.

In the scope of work for the PRO contracts are generic areas relating to the review of admissions, utilization and quality of care. In this way, we set the foundation for performance-based contracts, but left to the PRO bidders the responsibility to specify what particular utilization and quality issues would be addressed locally. It was also the PRO's responsibility to propose quantifiable performance objectives for addressing these issues.

One such objective of the Arizona PRO is to reduce unnecessary surgery and other invasive procedures. The PRO focuses on procedures with proven high complication rates and concentrates quality review activities on those cases. This year, for example the Arizona PRO will reduce by a target amount of 583 the incidence of unnecessary surgery or other invasive procedures within specific DRGs. Physicians and hospitals have been notified of the targeted procedures and the requirement for precertification of elective acute care admissions for these procedures. Where a pattern of inappropriate or unnecessary surgery is identified, peer review intervention will occur including education and where appropriate, sanctions will be imposed.

Concern has been expressed that under PPS, hospitals may be prematurely discharging Medicare patients. Let me emphasize that we have no evidence that there is a significant problem. As a safeguard against such practices we require PROs to review cases of hospital readmissions that occur within seven days of a hospital discharge. Where the PRO finds that the readmission resulted because of a premature discharge, it is required to deny payment for the readmission. In these instances, the hospital may not, in turn, charge the beneficiary for the readmission. Where the

PRO identifies other instances of poor quality it can take other corrective actions, including program sanctions.

Our concern for access and quality extends beyond PRO hospital review. For example, a measure designed to assure access to needed care is the swing-bed program. This program enables small rural hospitals to provide a skilled level of care to Medicare beneficiaries who no longer need the intensity of hospital care, but do not have access to a SNF bed. Six hospitals in Arizona are currently participating in this program.

We believe that the Medicare prospective payment system together with other competitive reforms implemented in the health marketplace and the overall decline in inflation have contributed significantly to slowing the rate of increase in the cost of the Medicare program and has prolonged its financial viability. When this Administration took office the medical inflation factor was 10.7 percent and is not down to 6.3 percent. However, current analyses indicate that by the beginning of the next century, the Medicare program will again face a financial crisis. Clearly, alternate forms of health care delivery must be evaluated in terms of improving the cost-effective provision of health care services to our increasingly elderly population.

ALTERNATIVE HEALTH CARE DELIVERY SYSTEMS

An important innovation in providing health care to Medicare beneficiaries is the recent change in Medicare's relationship with prepaid health plans. Medicare can now contract with competitive medical plans (CMPS) and health maintenance organizations (HMOs) on a risk basis. Reimbursement under risk contracts is at 95 percent of the usual cost of services. We consider these contracts attractive for both beneficiaries and the Medicare program. To date, 61 risk contracts have been awarded and about 360,000 beneficiaries are enrolled in these health care plans. These plans offer our beneficiaries an alternative to the traditional fee-for-service system. Beneficiaries will be free to choose between what we believe will be an increasing number of HMOs and CMPs. Among the incentives to join HMOs and CMPs will be the additional benefits these plans choose to provide over the standard Medicare package. Most importantly, should Medicare beneficiaries for whatever reason become uncomfortable with the HMO or CMP, they have the right to disenroll and rejoin the traditional fee-for-service Medicare system.

Another alternative health care delivery system we are studying is the social health maintenance organization. The social HMO provides a broad range of acute and long-term care health and social services to voluntarily enrolled elderly persons for a fixed annual prepaid capitation amount. Four sites (Minneapolis, Minnesota; Portland, Oregan; Long Beach, California; and Brooklyn, New York) are now providing services. The recently implemented social HMO demonstration will be conducted for 42 months and will be evaluated under a separate contract.

We are also conducting other significant demonstrations to test new delivery systems. To improve our ability to target patients for whom expanded home care services will truly substitute for institutional care, the Department conducted the National Channeling Demonstration. Conducted in 10 sites the channeling demonstration was designed to determine whether long-term care needs of elderly impaired persons can be met in a cost-effective way through a community-based system of care assessment, care planning and care management. the project combined innovative approaches to the organization and delivery of services with broader service benefit packages.

The demonstration was completed this year. A separate evaluation report will be completed in 1986.

To explore alternative approaches to providing and financing community-oriented long-term care, we also conducted a cross-cutting evaluation of 13 projects which provided community-based services to Medicare and Medicaid recipients.

The primary objectives include determining both clinical- and cost-effectiveness in providing comprehensive care to the aged and the chronically ill. Using providers of both formal and informal care, the project identified key factors specific to their host communities that contribute to or impede care. The final report on the cross-cutting evaluation is under review.

CURRENT INITIATIVES

Finally, I would like to describe the Administration's legislative and regulatory proposals for Fiscal Year 1986 as they pertain to PPS. They are an integral part of our overall efforts to refine the system and will help us hold the line on continued growth in health care costs.

The Administration will maintain the hospital prospective payment rates for one year at the current level. This action is strongly supported by sound programmatic reasons for not increasing the rates in 1986. In developing the PPS rates for the coming year, we have analyzed recent developments in the economic climate of the hospital industry which would affect their financial viability under PPS. Specifically, when we adjusted the projected hospital marketbasket for 1986 to account for decreased costs resulting from productivity increases and the elimination of ineffective practice patterns; applied a corrective factor to account for unforecast increases in case mix; and corrected an error in forecasting the 1985 marketbasket, our calculations indicated that a 4.42 percent decrease in the 1986 rates were justified. The General Accounting Office also believes that the rates may have been set too high because they were based on unaudited cost reports. GAO reported that this may have increased PPS costs as much as 4.3 percent.

The regulation contains a number of refinements in the system including a new wage index, based on our survey data, which takes into account area-by-area differences in part-time hospital employment practices.

For the first time since the introduction of PPS, all DRG weights have been updated to reflect technological changes, newer hospital practice patterns, and regrouping of certain diagnoses. These new weights constitute the most recent measure available of relative resource consumption across the whole range of DRGs.

Also included were provisions for implementing changes to the DRG classifications during a fiscal year.

Regulations effective for cost reporting period beginning July 1, 1985, have placed a one year limit on the maximum amount of allowable direct costs of approved educational activities. The limit is based on the lesser of a hospital's allowable costs of these activities during its current cost reporting period or during a base year, adjusted for inflation as needed. Limits were applied because these hospital expenses are currently reimbursed on a retrospective cost basis outside the PPS which does not encourage efficiency in operating approved programs.

Medicare also reimburses teaching hospitals in additional amount which recognizes higher indirect costs associated with teaching activities. Several years ago, HCFA developed a formula for determining how indirect costs of hospitals increased in relation to the ratio of interns and residents to beds. This percentage, currently 5.795, was doubled by Congress and specified as an additional payment in the legislation which established the PPS. Since there is no empirical basis for doubling the formula, we believe the substantial payments to teaching hospitals resulting from that action should be discontinued.

An indirect teaching adjustment recognizes, among other factors, that teaching hospitals may treat sicker patients with associated higher costs. We have undertaken a comprehensive research effort attempting to identify and define a system which will recognize differences in severity of illness among inpatients with similar diagnoses. It has been suggested that any change to the legislated indirect teaching adjustment should await the development of such a severity adjustment. We disagree. The formula developed by HCFA was based on recognized increases in actual costs of hospitals with teaching programs, which include costs associated with sicker patients. Therefore, prior to the legislated doubling, the indirect teaching adjustment already recognized those costs.

Of course, Congress is now discussing several proposals, including those put forward by the Administration which would affect PPS, and will make final determinations during the budget reconciliation process.

CONCLUSION

In conclusion, we believe our 1986 Medicare proposals are absolutely necessary to further the competitive reforms previously enacted and bring the growth in health care costs more into line with the growth of other areas of the economy.

We must continue our effort to assure that the financial stability of Medicare is not threatened. However, we must be careful that our efforts do not simply address a "collection of complaints" but reflect a well-considered approach to improving these programs through positive competitive incentives. We need to continue the kind of cooperation with Congress and the private sector that has resulted in the positive trends of the last few years toward our overall goal of making sure that the basic health care needs of our beneficiaries will be met in the future.

Thank you for the opportunity to appear here today and I will be happy to answer any questions you may have.

Mr. KOLBE. Thank you, very much, Mr. O'Connor.

We do have Mr. O'Connor's written testimony, and it will be placed in the record.

Perhaps this is a good point for me to mention that, as soon as possible—in about 4 months—we will have a complete printed record of this hearing available, and we will make it available to those that desire to have that. All the written testimonies will be placed in there.

The next person that will be testifying is Dr. Ted Koff. Dr. Koff.

STATEMENT OF DR. THEODORE H. KOFF

Dr. KOFF. Thank you.

Distinguished members of Congress, and the staff, and guests, I appreciate the opportunity to share with you, some of my observations about the system's problems with the DRG's, with some recommendations for change that I hope will be helpful to you.

I, too, have submitted some written testimony, and will use this as an opportunity just to summarize that.

I have the advantage, perhaps, of having shared observations with 10 other long-term care centers, which have attempted to monitor the impact of DRG's on older persons throughout the country. And my comments are both on Arizona and that which we have been able to glean from experiences nationwide.

I think there are about three major problems, that I can identify that seem to be the common thread of the concerns regarding the implementation of the DRG's. One is that, in fact, they have caused an earlier discharge. Now, whether or not that is good or bad is not the question, but there has been an earlier discharge as a result of the DRG's. As a result one of the problems may have been that insufficient time has been allocated for appropriate planning subsequent to the hospitalization. Not enough time, and perhaps not enough money, have been allocated to that segment of the system. This perhaps results in the advantage of an earlier discharge, but there are disadvantages of inappropriate planning thereafter.

The third point that we have observed is that there frequently has been a return to the hospital. Again, not being able to correlate that only with earlier discharge, this also may be a product of the care available after the initial hospitalization.

And, finally, one of the more perplexing problems that I see is that there may very well be a cost shifting, not just a cost saving, and the cost shifting may have gone to families rather than to any other organized payment system. So, what you get, ultimately, is pressure in many of these cases being redirected back to the family members, as we so eloquently heard described earlier. The burden to provide the care goes back to the family member, rather than to the payment system.

Well, those are some of the problems that we have identified that are the outgrowths of the DRG system.

I think we need to look at what the opportunities are, however, and the opportunities to improve.

We understand that one of the major characteristics of a long-term care system deals with the coordination of services, the continuum of services and the issue of case management. Case man-

agement applies to the planning, the organized planning for the continuum of care. So we have to think less about discharge from the hospital and more about transferring to a continuum. And I think what DRG's have established for us, at this point, is almost a dichotomy between health care systems: The hospital, and the rest of the world.

What is needed is integration, creation of some kind of a continuum in which the person is not discharged but rather transferred from one level of care to another. And the issue of case management becomes extremely important in that, because that is a recognized methodology that is available to provide this kind of transfer.

The critical issue is, obviously, that reimbursement mechanisms do not pay for case management and, therefore, we do not pay for a very significant part of what DRG's could achieve, which would be the appropriate transfer from one level of care to another. Case management is the least expensive part of the care system, and case management could make possible earlier discharge from the hospital, but with assurance of the continuity of the services after the hospital. So, we are being foolish in that we are not recognizing a very significant service that is available, and not being supported within the DRG system. So we need to think about how to incorporate the essence of case management and planning, to get a continuum going instead of a discrete chop off—out of one system into another.

Also, we note very frequently that the significant services provided to people at home, as was described in the earlier testimony that I thought was so very valuable, are those personal care services that enable people to remain at home, the bathing, the grooming, the feeding, the shopping, the bed-making, all of those critical services that enable people to remain at home and be rehabilitated at home and have the comfort and ease of knowing that they could be cared for at home, are not paid for under the current systems. What we need to recognize is that we have degraded a very significant part of the long-term care service, the personal care service, and have shunted that out of the mainstream of payments. That, also, is a less expensive part of health care, and by saving on it, I am sure that we have increased the overall cost of the program.

And, finally, I think that we have not given adequate concern to the problem of the very poor within this system. Because the problems of illness are more severe for those who are especially poor. The long-term manifestation of their illnesses, the inability to get access to the quick services that so many of us are privileged to have, cause more problems for the poor. And cost shifting back to individual households creates a burden that falls inordinately on the poor family, the poor household, where the kids need to work to support a family member who cannot work.

This cost shifting adds to the issue of deprivation of the poor. I think it transfers the cost savings to a segment of our society that can least afford to bear additional expense. And I think the pressure is on that segment, and we ought to have to give very careful consideration to that.

My final pitch to you, gentlemen, is that the long-term care centers have an opportunity to provide a service to you, and Congress, and to our society, by the continuing monitoring of programs that

54-636 O - 86 - 2

serve the elderly. And, unfortunately, the administration has decided to withdraw its funding of the centers. I plead with you to consider the importance of continuing to monitor these programs through support of programs such as ours at the University of Arizona.

Thank you, very much.

[The prepared statement of Dr. Koff follows:]

PREPARED STATEMENT OF THEODORE H. KOFF, ED.D., DIRECTOR, THE ARIZONA LONG TERM CARE GERONTOLOGY CENTER

My name is Theodore H. Koff. I am director of the Arizona Long Term Care Gerontology Center and this testimony is provided as a response of our program to your inquiry regarding the impact of DRGs on older people in our state.

It is important to recall for this discussion that our state does not participate in the Medicaid program and therefore the role of the county governments in providing services to indigent older people is especially significant. In addition, with support from the Flinn Foundation, a study of long term care in Arizona was completed last year in response to a request of the Governor and leadership of the state legislature. Our state at this time has a unique opportunity to examine the impact of DRGs in furthering the recommendations of the study of long term care in Arizona.

It also should be noted that this is a very important period in the development of long term care in the United States. In Arizona, the absence of Medicaid, the presence of DRGs and the need for a statewide long term care policy have created special pressures at a time when the Department of Health and Human Services has decided to end funding for all of the Administration on Aging supported long term care gerontology centers. Now, more than at any other time, centers such as ours are needed to conduct studies that are essential to responding accurately to your important questions.

The impact of DRGs on our older people requires careful monitoring and study and the long term care gerontology centers could have been a nationwide resource to provide useful objective research. The need for an evaluation component in the design of DRGs or whatever alternative funding mechanism may replace them continues to be essential. I therefore consider a request for advocacy on behalf of continued funding of the long term care gerontology centers to be a valid introduction to an examination of the impact of DRGs on older people in our state.

At this point our response is based on surveys of hospitals and home health agencies from which have been gathered anecdotal information, observations about trends, reactions of health care providers and recommendations for change.

One of the most significant characteristics of long term care services is that the services need not be carried out in a hospital; they can be provided in the person's home, a foster home, congregate housing, community service agencies or nursing homes. Long term care services, especially those needed following hospitalization, are to a large measure services that support activities of daily living (i.e., dressing, bathing, toileting, feeding, grooming). These are generally referred to as personal care or custodial care services. An individual's recuperative potential may be reduced by poor diet, unsupervised and misused medication routine, anxiety regarding the illness and loneliness or isolation. The true impact of the DRGs therefore may not be assessed simply by examining changes in length of hospital stay and any related cost savings. In fact, this variable may be of relatively minor significance when compared with the effects of shifting the responsibility for the provision of care from the hospital to the family and community agencies. We have observed that DRGs have been accompanied by very significant increases in the number of requests for case management and home delivered services. Such a change may reflect a significant shifting of the locus of service rather than a reduction in the actual consumption of service, and there may be additional costs associated with the shift, to some extent offsetting the cost savings associated with decreased hospital-based care.

In surveys conducted by the Arizona Long Term Care Gerontology Center and materials developed by the University of Texas LTCGC in collaboration with all of the LTCGCs nationally it has become clear that patients who are being discharged early because of DRGs often go home with too little time having been devoted to planning for the transfer and with insufficient funds available to pay for either case management services or personal care services at home. We believe that there may be a cost-shifting from the hospital to home delivered services, nursing homes or to family resources without provision of supplementary funding for the nonhospital

services that would permit them to continue the high quality services initiated in the hospital.

It has been our experience, based on the development of LTC services that, to be effective, LTC services have to be organized in a continuum that includes various levels of care, among them those services that are appropriate for post-hospital follow-up in order to support the person's ability to recuperate and be restored to wellness at home.

A distinctive characteristic of long term care, in addition to its having a coordinated continuum of services, is its taking a rational approach to the problems related to the transfer of persons from one service center to another by providing case management.

The comprehensive, coordinated package of service to those older persons disabled because of chronic illness, referred to as long term care, should offer continuity of services that are coordinated with the assistance of case management. In such a system patients would not be discharged from the hospital to another service network that has different rules and funding. Rather, case management would be called on by the hospital when a patient is admitted and would begin to prepare the family and household for the planned, scheduled transfer of the person from one service site to another.

In the assessment of the individual to determine readiness to leave the hospital primary consideration is given to the person's medical condition, response to treatment and the progression of the treatment plan. Yet of equal importance to an older person's ability to recuperate at home is the availability or absence of personal care services or family supports. Given sufficient advance time and the involvement of case management services, a careful assessment of the individual's personal care needs and the personal care resources of the household could be conducted. This is important in order to determine what resources will be required to support the person at home following hospitalization.

Some providers have reported that fewer transfers would have been made to nursing homes instead of to home care programs if adequate time had been devoted to preparing a plan to bring together the resources necessary to make a transfer to the home a viable alternative.

Some providers have also reported an increase in the number of readmissions to the hospital that may be a product of too early a discharge or inadequate provision of home delivered services. In the overall picture, insufficient time has been given to the development and availability of home delivered services and insufficent funds have been allocated to the provision of these services.

Careful consideration should be given to the inclusion of case management in any health cost containment program so that a package of services could be made available following hospitalization. Appropriate funding of this component would permit realistic determination of actual costs.

More and more individuals who may be temporarily impaired after hospitalization require a mix of services that will enable them to return to a functional status and avoid further costs for institutionalization. Providing and financing a range of community services are critical to an effective long term care system. Policy and funding priorities must be re-ordered to include them if we are to have a long term care system that responds to the need of the elderly.

WHAT IMPACT WILL DRG'S HAVE ON POOR PEOPLE?

Poor and non-poor patients have some different characteristics. The poor generally cost more to treat, stay in hospital longer and may be more seriously ill. They may wait longer for treatment and have fewer supports at home. Cost shifting to reduce the federal costs of caring for the poor usually results in increased costs to another level of government such as the county or in the denial of supports not covered by Medicare. Poor housing, limited family resources or working family members often make discharge of members of poor families to their own homes difficult. As a consequence, poor older persons may frequently be returned to the hospital or have to be placed in a nursing home rather than be cared for at home. In DRGs, as in other programs, reducing funding of health and social services may mean that the poor older person will suffer the greatest loss. In Arizona, county governments will be required to step in to meet the needs of its medically indigent.

In summary, I want to list some of the critical issues related to DRGs that should receive your careful attention.

The long term care system is dependent upon the coordination of services in a continuum. The DRGs seem to have caused greater separation between hospital and non-hospital care because of the absence of a coordinated funding plan to bridge the

institutional and noninstitutional services. If funding is used as an instrument to reduce the use of hospitals, funds should be made available to provide for reasonable substitute care at home.

The critical service most needed to support safe and orderly transition from hospital to home is case management following an appropriate assessment of the individual. This plan should result in moving the individual into an organized support system instead of abrupt discharge from the hospital without assurance of an alternate care system.

Involvement of case management services and planning for transfer should be funded under DRGs and initiated at the time the individual is admitted into the hospital.

Medicare funding of home health care should be reorganized to include a significant portion of the personal care services essential to enabling the older person to remain at home.

Critical attention should be given to the adverse impact of DRGs on the poor older person who may not be able to respond to cost shifting by assuming a greater share of the costs of service.

The DRG program should have an evaluation component to provide answers to the questions of the impact of DRGs on the older person. The Arizona Long Term Care Gerontology Center, along with the other 10 centers nationwide, should have continued federal funding to provide the evaluation of DRGs and contribute to the development of a rational, comprehensive long term care system.

Cost containment is of legitimate concern to the American public. But this concern must be balanced with quality of care and an assurance that all elders in the United States will have access to a basic level of health care.

Mr. KOLBE. Thank you very much, Ted. Dr. Duncan.

STATEMENT OF DR. DONN DUNCAN

Dr. DUNCAN. Thank you.

I would like to thank the members of the subcommittee and Congressmen Jim Kolbe and John McCain for this——

Mr. KOLBE. Could you get the microphone up just a little bit?

Dr. DUNCAN [continuing]. For this opportunity to be here and address this group today.

Can you hear me, now?

Mr. KOLBE. Yes; it's working. You just needed to be close enough.

Dr. DUNCAN. Is this better?

Mr. KOLBE. That's OK.

Dr. DUNCAN. I'm glad I'm not the last speaker. The eloquent testimony that we have heard is really covering the topic very well, especially Ms. Smith, who I thought was especially eloquent, to help us focus on some of the real problems that have occurred under the system.

In the late 1960's, and into the 1970's, people in the health care industry were attempting to find a way to measure quality and to measure resources used within a hospital setting, and that is why the DRG's were formed.

What the DRG did, which is actually quite exciting for an industry that is as old as health care is for the first time it gave it a real product definition. The definition, before in health care was a blood test, an electrocardiogram, a chest x ray, those things that happened to you in a hospital. After the DRG's, for the first time, the definitions were then the diagnosis and the treatment required for pneumonia, for having a baby, for breaking your leg.

The implications of this are significant, when for the first time, we can now compare hospitals and doctors. And there is much excitement in the system, because, as we have seen, there are now comparisons that can now be made between the hospitals and the

doctors. In fact, there are many times when we sometimes do too much for patients.

For example, routine chest x rays are perhaps not only not indicated, but in the long term, may be somewhat harmful, when accumulated with other x ray exposures. So, this system has actually done quite a bit to help us compare and look at, in an educational sense, and a very positive sense, at health care.

We are here today, to find if we are moving toward an incentive that will create an environment where we do too little, and all of us are very concerned about that. And I appreciate the first panelists, especially telling us their situations, and Dr. Koff, in particular, who has told us that we are now having a shift from the excellent care in the hospitals to additional care which is needed outside of the hospitals.

The system, itself, must be remembered to be a very dynamic system. The dynamic system of health care is always changing, and the system per se is not a threat, I do not believe, to health care. The greatest threat, are the methods and the manner in which we reimburse and give incentives in this system. It is the challenge of Congress and of HHS, and of HCFA, to make sure that the DRGs, or the reimbursement system, is appropriately given the monies for inflation, the cost of goods and services for new medical technology, and for education that is needed within the system. If the system does not receive adequate money, the incentives will be for further early discharge, for less testing and for less treatment, and the system will respond in that manner.

So the challenge is, to our Congress and to HCFA, to make sure that there is not an artificially set low payment for particular DRG's, because the system will indeed respond to inhibit accessibility for these DRG's, and for the things that we have heard in the prior testimony.

I had also the same concerns about quality, and so the first study we embarked upon was to look at the local institutions, where we could not find specific objective evidence of premature discharge injuring patients which is most critical. They could not find that occurring.

The Pima County Medical Society had 27 written inquiries last year, where there was no evidence that the PPS or the DRG system was specifically decreasing the quality of care.

The Arizona Hospital Association had 120 inquiries during the same period, again, without implicating decreasing quality of care in the DRG system.

The PRO organization, which we have heard described, and Dr. Shapiro and Mrs. Nixon are here today to discuss this with you, is the former HSAG or Health Systems Advisory Group for the State of Arizona. They recently reviewed 40,000 Medicare discharges. Of those 40,000 Medicare discharges, 440 were readmitted within 1 week or within 7 days—12 of those 440 chart examinations were potentially implicating premature discharge, and I think the study is ongoing at this time, to see if that indeed has occurred, but it is not a strong indictment of the decreasing quality of health care.

Let us look at the other side, where Dr. Koff has just given us testimony. We also went to the nursing home, which is the next level of care after the acute inpatient hospital care, and indeed,

that environment is being sorely stressed and stretched, in its capacity.

They are having significant problems. For the first time, one of the large institutions in this county has started I.V. therapy, which certainly implies that patients are in need of additional care. In addition, they have what they call an acuity measure, where they are measuring the acuity of the patients that they receive from the hospitals. They have found that there is an increasingly greater need for activity, support for feeding, and patient orientation is not as good. Their patients however, are also coming to them somewhat older.

I certainly agree with the prior testimony, and the need for making sure that we have the funds for the next level of care after inpatient health care. We must remember, though, that there are certain advantages in not being in a hospital. In the hospital, there may be complications. Fifteen years ago, when you had your hernia operation you were in 10 to 15 days. Now, you go in overnight, and in some instances, as an outpatient. However, 15 years ago, people had pulmonary emboli. They developed nosocomial infections and sometimes medications were confused. So, we have seen in certain instances, in this mixed bag which we are trying to understand that the quality of care may have indeed improved. We must keep in mind that is indeed occurring.

In this community, there is a growing need for support on the level that Dr. Koff mentioned. In the last 2 years, from 1983 to 1985, the home health care units have increased from 4 to 26. The marketplace is not wrong for long. When they realize there is a great need, they will come to satisfy that, and I think that is a significant change.

Also in this community, within 1 year, there has been an increase in the information and referral services requests of 140 percent. So, indeed, we have a real need that we must address.

I would like to close by stating that, in a country which is as privileged as ours, and where we have 12 percent of our population needing, truly needing, approximately 50 percent of our inhospital health care resources, the system needs are adequate alternatives to acute care hospitalization and adequate reimbursement for those alternatives.

It is important that we do not change health care in our rush to change health care incentives. The practice of medicine, and the relationship of doctors with their patients is very special, and our health care system, I believe, is the best in the world. Doctors from all over the world come here to train. Patients come here to be treated, and let us not arbitrarily make decisions to change superiority to mediocrity, and quality to inadequacy.

I thank you.

[The prepared statement of Dr. Duncan follows:]

PREPARED STATEMENT OF DR. DONN DUNCAN

Thank you, members of the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging, and Congressmen John McCain and Jim Kolbe for the invitation to appear and testify.

BACKGROUND

I am a physician engaged in the active practice of otolaryngology and head-neck surgery, and was elected as Chief-of-Staff of one of our local hospitals. During that period the Joint Commission of American Hospitals (JGAH) first required hospitals to have a quality assurance program written and in place. Upon investigation it became apparent that to measure quality, medicine had to have or develop a better definition of its products. The diagnosis related group (DRG) system for measuring resource consumption satisfied that need. The search for this system led to my participation with members of the original development group from Yale University.

OVERVIEW

The most important aspect in evaluating the effect of the Prospective Payment System (PPS) with DRG's is that the system is being used in a dynamic and rapidly changing environment, health care. It is not this system that poses the greatest danger in compromising the delivery of health care to the elderly, but the possibility that decisions by Congress or the Health and Human Services (HHS) are political decisions where rates are set artificially low, and do not truly reflect inflation and the real costs of goods and services incurred by providers. This has the effect of amplifying the incentive for early discharges, inadequate testing and treating, and inappropriate admissions. Another aspect of the dynamics of health care is seen in the continuing evolution of new medical technology, disease treatments, and diagnostic techniques which require that the regulatory mechanism is sensitive to these changes and reflects these needs rather than penalizing the system.

RESPONSE TO QUESTIONS

Does the DRG system place physicians under increased pressure to discharge patients earlier than would otherwise be the case?

The DRG system unequivocally increases the pressure for earlier patient discharge through several avenues. The existence of the system for the first time gives an awareness of the economics involved especially to the physician as well as the hospital. Previously the "cost-plus" reimbursement environment not only did not motivate this economic concern, but in fact rewarded inefficiency. The system now gives the physician, when discussing discharges with patients, supportable reasons for "timely discharge" rather than "convenient discharge".

There is also evidence that some institutions may be exerting pressure, albeit subtle, on physicians to discharge patients earlier through the profiling of physician "winners" and "losers" relative to DRG reimbursement and presenting these in an open environment, i.e. staff, department meetings, with the implicit threat of privileging. There will be mistakes made in decreasing the length of stay (LOS), but it is the intent of the system to shorten hospital stays. Even with conscientious physicians there has been slack in the cost-based system, and physicians are sincerely trying to make the new system work.

From this new incentive there are several beneficial outcomes which result in better utilization of hospital resources with earlier discharges, sequencing, test scheduling, operating room scheduling with weekends and extended days, A.M. admitting for surgery, and timely initiation of discharge planning. A study conducted by McKinsey and company demonstrated as many as 42 percent of all inappropriate hospital days can be attributed to delays in discharge planning.

Does the DRG system create cost-saving incentives which create the danger of compromising the delivery of medical care to the elderly?

The greatest danger in compromising care is in refusing treatment to patients in those DRC's where the reimbursement is inadequate. Once patients are "in the door" or admitted it is the nature of the system to deliver and protect the quality of care through quality assurance programs, risk management, and Professional Review Organizations, in addition to the specter of malpractice. An argument can be made that though increased savings might be realized by placing physicians under a DRG or similar reimbursement system, the current status creates a "healthy tension" between physician and hospital without discouraging screening, testing, and extended stays, when felt to be indicated by the "not at risk" physician. However, in the capitated systems such as HMO where shorter stays and fewer admissions are recorded, it appears that quality has been maintained. There is concern that this is short term and that there may be a deferral of care.

In Arizona, to determine if outcomes manifested by patient complaints implied premature discharge or compromised quality, several institutions were queried. Tucson Medical Center, Pima County's largest acute care facility with 650 beds, re-

ports, "relative to patients being discharged early, we haven't seen any evidence of that occurring". The Pima County Medical Society reports receiving between, June 1984 and June 1985, 27 written complaints from patients but none concerning Medicare or the Prospective Payment System. The Arizona Hospital Association between July 1984 and July 1985 had 126 inquiries with none implicating potential early discharge problems. The Arizona state Professional Review Organization (Health Systems Advisory Group) has reviewed 40,000 Medicare discharges and found 440 readmissions within 7 days, with 12 cases being investigated for potential early discharge.

Are there particular aspects of the DRG system which must be monitored, either by Congress or the Department of Health and Human Services, in order to assure that the quality of health care does not deteriorate?

It is the area of refusing patients' accessibility to health care that is of greatest concern. The natural checks and balances of the system take over when the patient has been admitted. It is critical that the DRG reimbursement scheme accurately reflect the costs of delivering services, especially if potentially all hospitals in a particular area would inhibit access to care because the DRG payment is predictably not high enough to cover costs for that particular DRG. For monitoring, the PRO is the appropriate source, as they are collecting and have access to data. HCFA should construct quality evaluation studies selecting groups of hospitals and DRG's to study complications, readmissions, outcomes, and delayed admissions or deferred care.

Will the DRG system serve successfully over the long term in restraining the rise in health care costs?

It appears that the DRG system has significantly participated in the lowering of health care costs and will continue to do so, at least in the intermediate term (5-6 years). The system will most likely evolve over the longer term and require capitation to control overall costs of health care, which will increase as the home care, skilled nursing facility, outpatient, and ambulatory care migration continues, and the aging of the hospital population progresses. A study by the National Council on Community Hospitals indicates that more patients older than 65 years of age are being admitted to their institutions, and it is apparent that the HHS is migrating from the assumption of risk in health care reimbursement for Medicare and desires to shift this risk to the providers of health care through capitation.

Overall, the DRG system appears to have had significant success with lowering of the LOS and admission rates. In the West even where the length of stay has traditionally been shorter there has been a decrease in the length of stay approaching 20% in Tucson since 1981 (from 7.3 to 5.9 days).

Are hospitals under DRG's discharging patients "quicker and sicker"?

Hospitals may be discharging patients "quicker and sicker", but is it necessary for those patients to be in the hospital? It is the physician who discharges the patient not the hospital, and the physician who determines when the patient is well. Not long ago hernia surgery patients were hospitalized for ten to fourteen days and when discharged they were virtually pain-free and fully active. We now may discharge them after very short stays and on occasion they may be treated as an outpatient, with improved outcomes. There is evidence that longer hospital stays may be related to increased infection rates and complications. Indeed there is evidence that the general quality of care may be improving, and if certain services are still needed they may be better delivered as an outpatient, at home, or in intermediate care facilities or skilled nursing facilities. A survey by the National Council of Community Hospitals shows that though there are more elderly (over 65 years) in their hospitals the death rate is actually dropping (4.9%) from 1983-84. This has occurred, in spite of a recent increase in the LOS and the cost per patient, implying more complicated cases as reported by the American Hospital Association during the first quarter of 1985.

It is not "are patients leaving the hospital quicker?", which is reflected in the LOS statistics but more importantly, are they leaving the hospital "inappropriately early", suffering complications, unsatisfactory outcomes, and readmissions? A study of the New Jersey Project by eight independent investigations did not demonstrate evidence that there was deterioration in "quality" as measured by readmissions or malpractice frequency.

It is possible that some patients may be discharged at a time in their illness when they have substantial needs for care.

It is possible that some patients may have greater needs. It is the natural incentive of the system in addition to the aging of our population that we can expect greater demand on our next level of care after acute care facilities. In Tucson, in responding to this need there has been an increase in licensed home care agencies from 4 to 26 between 1983 and 1985, and just prior to that (1982-83) the Information

and Referral Services reported an increase in requests of 140%. We are returning in part to the pre-insurance coverage era, when many illnesses were cared for out of the hospital. It will take a period of time before the recipients of this care are able to sort through all the confusion that is occurring. What the system needs are adequate alternatives to acute care hospitalization and adequate reimbursement for those alternatives.

It is important that we do not change health care in our rush to change health care incentives. The practice of medicine and the relationship between doctors and their patients is very special. Our health care system is the best in the world. Doctors from all over the world come here to train, patients come to be treated. Let us not allow political decisions to change superiority to mediocrity and quality to inadequacy.

Mr. KOLBE. Thank you, doctor.

Whenever we try to put together a hearing like this we try to make it as balanced as possible, and make sure we cover all the bases. But I think it is likely, based on what we have heard here today, that we neglected in not including somebody from the Peer Review Organization. And fortunately, he is in the audience, and I am just going to ask Dr. Lawrence Shapiro if he would just come up and join us and make a comment.

Several people have asked how does one contact the Peer Review Organization, and perhaps comment on some of the things that have been said. Dr. Shapiro, would you join us up here, at the table?

Thank you for this impromptu addition to the panel.

STATEMENT OF DR. LAWRENCE SHAPIRO

Dr. SHAPIRO. I would like to take advantage of this opportunity to make just a few comments about the operation of the Peer Review Organization for the State of Arizona. We are hired by the Federal Government to attempt to be certain that the care provided to Medicare recipients in hospitals is appropriate care. That is to say, if the patient is in the hospital, they need to be in the hospital, and if they are going home, they are ready to go home.

What our goal is, is to make certain that the care provided is appropriate to the patient's needs.

Now, in days before prospective payment, or DRG's, the problem was always that patients might stay in hospitals for longer periods of time than was actually necessary. And, now, things have reversed, and people are concerned that they might not stay in as long as they actually need to. It was mentioned that the average length of stay for Medicare recipients since the DRG's have been in effect, the average length of stay has decreased. But I would point out to you that one of the reasons that it has decreased is because many procedures that used to require hospitalization for say, 2 or 3 days, namely, the most common of all Medicare operations, cataract surgery. Those are no longer hospital admissions. So, with the absence of many, many 2- to 3-day stays, of course, the average length of stay for Medicare recipients goes down.

Mrs. Soash, in her earlier testimony, tells us many things, but as we all observe her, we see a woman who is in command of her faculties for the most part. That is to say, absent the left arm. We see a woman who needs care but the question is, do we see a woman who needs to be in the hospital? The answer is likely, no. She needs help. She does not need to be in the hospital, and Dr. Koff is

right on top of this by saying something has to change in order to make this kind of help available to her, but not in the hospital, not in the hospital.

All right. Now, Congressman McCain early on, mentioned PRO's discharging patients. That does not happen. The PRO never discharges a patient. A hospital never discharges a patient. In order for a patient to leave the hospital, it has to be on the order of the physician or on the decision of the patient that they do not want to stay any longer, but a physician must order a discharge, unless the patient is desirous of leaving without the physician's approval. So, that if in fact, someone thinks that they are being sent home too soon, and their physician agrees, there is nothing in the world that will get them out of the hospital, nothing.

The hospital will not lead them to the door and throw them out in the street. It simply will not happen. The patient will—if the hospital thinks that the patient should go home, but the doctor does not—that is the kind of question that the PRO becomes involved in, and the information from both is submitted and a decision is made by the PRO.

The worst thing that can happen, and it is important to remember this and it is a bad thing, but the worst thing that can happen is that the patient may become liable for payment of a certain portion of the hospital stay, but that is the worst thing, and if anyone thinks that it has become common practice to take elderly people and shoot them out in the street because the hospital is no longer generating a profit by their stay, they are fatally wrong. That does not happen.

So I am trying to put an awful lot of information into a couple of minutes, but, in essence, this is what I have to say about the PRO.

Now, insofar as our availability, we do not serve as an organization which fields patient complaints. We do not serve in that capacity. However, Representative McCain, I know, has forwarded to our office, some questions and we have corresponded with his office and with the offices of others of the elected officials from the State of Arizona, but we are available.

We have been in contact with the American Retired Persons Association. They have named some representatives to one of our advisory committees, so we do recognize that we need input from the community.

We are available, and I trust this has given everyone at least an idea of the fact that we do exist, and we do serve the public, we trust.

Mr. KOLBE. Thank you. Please stay there at the table, because we may have some questions for you. In fact, I'll just start off, if I might.

You do not take complaints or cases directly, then, from patients. How are most of your cases referred when there is a dispute between a doctor and a hospital and an insurance carrier, or HCFA, itself? Whom are most of the referrals from?

Dr. SHAPIRO. When there is a dispute in that sense, of course, those complaints do come to us directly. And I did not mean to say that we are insensitive, or that we do not want any public input to our office, but if we do receive such input, it should be in the form of written communication.

Mr. KOLBE. Right. So, you——

Dr. SHAPIRO. We will provide for you our mailing address.

Mr. KOLBE. Thank you. I appreciate that, and we will put that in the record, if you would do that.

If you do receive a letter from an individual who feels that they have been incorrectly discharged, you would put that in your system, then?

Dr. SHAPIRO. Yes.

Mr. KOLBE. Let me go back and ask you a general question on something you said.

You referred to the decline in the length of stay and the fact that modern technology and better medical care is contributing to that. Is it your view that that is more the contributing factor in the decline of stay in the hospital, than the DRG system pushing on the cost end?

Dr. SHAPIRO. I think, when we talk about average length of stays, and we find that, in the State of Arizona, that the average length of stay has now fallen by about 1 day, we think that is the prime explanation, yes.

Mr. KOLBE. That raises another question, and this is a question that I would address to the entire panel.

If, indeed, modern medicine and technology is driving down the length of stay and the length of stay can be shortened, then, obviously, that suggests that we need to go back and constantly refine the DRG system to reflect that. Then we have shorter length of stays. Then there is more pressure to put the length of stay down, even further, so how do we balance that? How do we know when we are pushing too far on that?

Dr. Duncan, would you like to start?

Dr. DUNCAN. Yes, thank you.

I think there are two very important points to make. One of which I did make and the other I neglected. That is, first, make sure that the system is paid for its cost, and costs that have given us the high standard of health care we now have.

In other words, medical technology costs, true inflation costs, the costs of delivering goods and services.

We do not want Congress or HCFA to ratchet down inappropriately the reimbursement to the institutions. I think that is an important point.

Second, and—one of the few times I am going to disagree with Ms. Smith's terrific testimony—in that it has occurred to me that the healthy tension that exists between physician and hospital may be a good thing. We are the patient's advocate.

If we bring patients within a physician DRG or an RVSFR, or whatever system is currently being contemplated, the patients, themselves, may have lost a real advocate for an extra stay, an extra test, things that the physician now feels somewhat free to do, although there is pressure. I would hate to see us lose this.

It is my recommendation that consideration be given to not include physicians in the system, so they remain truly the patient's advocate, and that will, in a large part, protect the patient within the system.

Mr. KOLBE. Thank you.

Would anyone else like to comment on that? Mr. O'Connor?

Mr. O'CONNOR. Mr. Chairman, I would like to underscore something that Dr. Shapiro pointed out.

Mr. KOLBE. Pull that microphone up close to you.

Mr. O'CONNOR. In connection with the change in the average length of stay, remember that is just an average. The actual time that any patient goes home depends on his own physician making a judgment. In some cases, the physician is going to judge the patient can go home in less than the average length of stay, and sometimes in more than the average length of stay, but it is always the physician who looks at the individual patient, and, to my thinking, that is the biggest protection in the system.

Dr. KOFF. If I may be repetitious, again.

My concern is not with the reduction in the average length of stay, but rather the availability of appropriate follow-up. And I think the reduction in the hospitalization stay has many very positive characteristics. But we have to complement that with opportunities for appropriate care when the patient comes home. Essentially, it means payment for that appropriate care, because the care is generally available, but folks do not have access to the payment that would enable them to use it appropriately.

Mr. KOLBE. Mr. O'Connor, you said, in your spoken testimony to us, that—you referred to the fact that we ought to make all the refinements we can, whether it is severity of illness or whatever.

It occurs to me that if we make all the refinements that we can, if we add in the severity of illness, and we have regional, and also different labor costs, and we have refined the DRG group so that we have more of those, and we have multiple ones, and we have age in there as a factor, we are getting away from the averaging, are we not, and pretty soon, we are back to a system where it is reimbursement for services for every single case. It is an individual case.

Mr. O'CONNOR. No, I——

Mr. KOLBE. Is that not——

Mr. O'CONNOR. I would disagree somewhat.

The payment—for example, if you can refine the DRG, what you are doing is taking a whole block of diagnoses, and separating them into segments. Now, some of them may be more expensive than others, but you would still be averaging with whatever segment that you elect. You would just be getting further away from the problems in which perhaps the range of costs were too great inside of a particular category.

I hope that helps somewhat.

Mr. KOLBE. That helps some.

I will ask the next panel this question, as well. But I have heard it suggested that hospitals are getting so refined in their diagnostic techniques, that they now are able to put all the systems into the computer and come up with a range of diagnoses, and, based on that range, will admit a patient under the diagnosis that gives the longest stay.

Have you had any evidence of that? I guess the broader question I am asking is, is there any evidence that hospital physicians, whoever, any place in the system, are manipulating the diagnostic systems in order to get it?

Well, Dr. Duncan can answer, and you can, also, Mr. O'Connor.

Mr. O'CONNOR. So far, we have seen remarkably little in the way of attempts to manipulate the system.

Remember when the system was being debated before Congress, one great concern was that hospitals would attempt to overcome the payment limitations of the DRG system by admitting more patients, and therefore getting more DRG payments. That did not eventuate at all.

The number of admissions has gone down under Medicare, just as they have in all other programs

I think there will be cases in which there will be disagreement between HCFA and the hospital on whether it is this DRG or that DRG, but we really do not see or have we, as yet, developed evidence of any systematic attempts that are wide scale. We have some cases that we have under investigation, and I should say, in that connection, if there are hospitals that are discharging people against the doctor's order, and harming their care, these cases should be reported to the PRO or the Health Care Financing Administration in San Francisco, because those hospitals should not and will not be in the Medicare Program very long.

There are provisions of law passed by Congress by which such a hospital will be excluded from Medicare, and we will move to exclude them when we get a case like that. Each case we find is presently being investigated. If you have a case, send it in.

Mr. KOLBE. Dr. Duncan, did you want to comment on that?

Dr. DUNCAN. One final comment.

Statistics just released by the American Hospital Association are very interesting in that we may have rung all out of the system that we can. The first quarter of this year, they have seen the length of stay begin to rise 1.1 percent which means we may have bottomed out, which is of great concern.

In addition, the cost per patient per day has increased dramatically, and is approaching 11 percent in their studies. So, again, it behooves us to be very careful not to put further disincentives into the length of stay in the reimbursement formula that they receive.

Mr. KOLBE. Could that rise in the cost be, in part, because, if we are discharging patients at the other end earlier when they do not need the hospital care, then those that are in are more severely ill, and truly need the hospital care, and that costs more?

Dr. DUNCAN. Exactly.

Mr. KOLBE. I really do not have any more questions. And I want to let John have a chance here. But let me ask one final question of Dr. Koff.

You talked about case management, and I could not agree more, but who ought to have the primary responsibility for case management for patients? Do we need to add a whole new layer in this, and should that be the physician? Do we need to have a new patient advocate or the primary physician for a patient?

Dr. KOFF. I think we have a structure established now that can serve that well, and can be utilized in that way. In many communities, it already is assumed that the Area Agencies on Aging networks, appropriately located throughout the whole country, wherever there are masses of people is the structure. These organizations are prepared to assume that responsibility. They have been

trained. They have staff who are ready to do the work if the money were there for them to do it.

I do not think we need an overlay of another structure; I think we have the existing structure to handle that.

Mr. KOLBE. That raises a point. You are talking about the fact that Medicare does not cover many of those services, post-hospitalization services, but the Older American Act does provide many of those same services you are talking about, do they not?

Dr. KOFF. The Older Americans Act does not specify those as reimbursable services, except as it is made part of the local plan, and then it is in competition with all the other services that are needed.

The kind of thing you are saying is, increase demand on the local service system without any increase in the funds.

Mr. KOLBE. I see.

Dr. Shapiro, did you want to comment?

Dr. SHAPIRO. In regard to the case management setting in which it ought to occur, certainly, it is advantageous for the hospitals to begin discharge planning at the time the patient goes into the hospital, to try to make certain that the hospital, or that the patient's family or that friends or that social service agencies, or some help is available to the patient when he goes home.

I suspect that it will fall to the hospitals primarily without setting up another layer of organizations. Hospitals will find it convenient for them and wise for them to make sure that the patients can go home when they no longer need the acute care setting that the hospital can provide.

Mr. KOLBE. Thank you. John.

Mr. MCCAIN. I will try to be brief.

Dr. Shapiro, I either misstated, or you misunderstood my statement about discharges from hospitals. I am aware that it is the doctor who orders discharge. And I am also aware that, in some of the cases you mention, I referred to your organization, because of the unique relationship between the doctor and the hospital.

It is my belief that, on occasion, pressures are brought on a doctor by the hospital administration to discharge a patient. I do have some documentation which that indicates that it is not a verdict of guilty, but that something happened which caused those patients to be discharged earlier than, in my judgment and the judgment of other experts, what was called for.

I hesitate to disagree with the experts, but I would also like to mention the subject of the reduction in length of stay.

We continue to make advances in medical technology, but it is only in my belief, since the inception of the DRG's, that the length of hospital stay has been reduced—or dramatically reduced, as it has been in the last year. Prior to DRG's, length of stay was not steadily declining and now it seems to be. I believe there are other factors aside from the increase in advances in medical technology that have caused a reduction in the length of a hospital stay. I am very interested in Dr. Duncan's statement, "that we are now seeing a slight increase."

I only have one question for everyone. Certainly, if you care to rebut that, please go right ahead.

Dr. SHAPIRO. I would, though I certainly would not disagree too strongly with the Congressman.

Mr. MCCAIN. Lots of people do.

Dr. SHAPIRO. I would point out this to you, that it has been suggested here that hospitals today are different than hospitals used to be, in that the patients who are in hospitals today are much, much sicker than they used to be. And the reason for that is, that if you are less sick, you can receive services outside the hospital. You do not go into the hospital.

For instance, if in days gone by, you had 100 patients admitted to the hospital, 20 of which had cataract surgery, and stayed 2 days, and the other 80 did not, the average length of stay there is affected by those 2-day stays. Now, you do not have any cataract patients admitted, or almost none admitted, so, the 100 patients are all sick. The average length of stay is going to go up, but only to a point, you see, and then it is going to level off. This is one point.

Now, as far as the pressures that might be put on physicians by hospitals to discharge patients, this really is nothing new in that if we go back to the beginning of Medicare, there were always points along the way where the Government would ask that we reassess the need for hospitalization, you see. And that is being done, and when the need is no longer there, the hospital will call this to the physician's attention and the hospital may very well say that this patient is not receiving acute care at this point, and is it not possible to discharge the patient.

Mr. MCCAIN. Thank you.

Let me just make one quick recommendation to you before my final question. And that is that your organization, return and examine ways to make your deliberations more open to various advocacy groups, such as the AARP, the Gray Panthers, and others, so that they can feel that they are a part of the process. I believe that is very important.

Very briefly, for the other three witnesses, I am concerned about the severity of illness index. Numbers indicate that the fastest growing portion of our aging population is age 85 and over. My information is that somewhere around 150,000 Americans in the year 2000 will be over the age of 100. And, to me, this puts a different emphasis on the DRG's, in that it is obvious that the older Americans need or require different kinds of care than those at age 65.

I will briefly ask the other three witnesses for their thoughts on the severity of illness index. We can start with you, Dr. Duncan, if you would like.

Dr. DUNCAN. Thank you. And it is a very appropriate question.

The reason that it has not been specifically addressed, and put within the DRG's, is that it may not be directly related. The severity of illness is not necessarily directly related to the resource consumption within a hospital. For example, none of us can be more terribly ill or sick than dying of terminal cancer. Yet, when that patient goes into the hospital, he consumes the least resources of most patients in that institution.

A person that goes into the hospital with acute chest pain, and not having a heart attack, that person will probably consume more resources in the hospital than the person who does have a heart attack, through investigation and different tests. So, all attempts to

directly relate the severity of illness and resource consumption, which is the key that we are trying to address here, have been to no avail at this point.

However, HCFA, I know, is working on trying to integrate this. The group that I am associated with is working with perhaps the leader in this, Susan Horn, from Johns Hopkins. This is being addressed, and I am hopeful that this will be put into the formula in some manner.

Mr. MCCAIN. Dr. Koff?

Dr. KOFF. Congressman, I think, in addition to what you are saying, is the issue that I wish we had more time to talk about, which might be called compression of morbidity. I think the thing that we will find is that there will be more people living a longer life in better health, and that will be a product of more money put into good opportunities for living during their youth and earlier stages of life, but will come into a very severe period of a few years of severe morbidity, and I think we have to look at the system and some of those changes where there is a postponement of very high costs to a very brief period, and the need to have services available at the intensity required at that time.

For the time that we have, now, I would just like to offer that as another thought related to your comments. And I think that we have to look at those changes, as well.

Mr. MCCAIN. It is my understanding that 30 percent of health care costs incurred by the average American are during the last 6 months of his life.

Dr. KOFF. Yes.

Mr. MCCAIN. That, obviously, illustrates your point.

Mr. O'Connor, would you care to comment?

Mr. O'CONNOR. I think that, certainly, the question is not simply severity of illness, but many factors inside of a particular DRG that cause a disparity in the resource consumption for that DRG. Now, as the doctor indicated, experts are working on that. I would not attempt to say what they will come up with when they are finished with their deliberations, but I just hope that they do it well.

Mr. MCCAIN. But do you agree that there is a need for this?

Mr. O'CONNOR. I think the DRG system is a brand new thing under the Sun, and I think every aspect of it ought to be studied thoroughly.

Mr. MCCAIN. Thank you, very much, sir.

Mr. O'CONNOR. If I may, sir. One thing that I would point out is that a number of people have talked about the need for improved services in the community. And I would point out that in my prepared testimony, I described three kinds of demonstrations that are now underway in our department, one of which is a national channeling demonstration where the demonstration is complete. It is now in the evaluation stage. There are several other very significant demonstrations, such as social HMO's and I would like to recommend that section of my testimony to you if I may.

Mr. MCCAIN. Thank you, very much.

Mr. KOLBE. Mr. O'Connor, I read that with interest. I was particularly interested in that national channeling demonstration.

I have a lot of other questions that I want to ask. Perhaps, we will have another opportunity to do so. I wanted to conclude with a couple of questions.

Dr. Duncan, in your written testimony, you said that the greatest danger is that the political decisions are going to override the medical decisions in the DRG system—the real demands of the health care system, and it certainly is a real danger.

Do you have any suggestions to those of us who are politicians and have to make political decisions, as how we might guard against that type of development? And I might ask at the same time, would it be your assessment that the administration's recommendation that the DRG reimbursement be frozen at the current level this year is an example of political decisions being made regardless of the medical decision or the cost data decision which is available to us?

Dr. DUNCAN. Yes. The answer is yes and that is correct. I gave in both my written testimony and part in my oral testimony, that what is perceived is the system appears to work well. It is how we manipulate the system that is of concern. And I did not say that it will happen, but we are very concerned that, if the rates of reimbursement are set artificially low, and not truly reflective of the costs that the providers have due to the inflation, the costs of delivering services, medical technology and of education, things that go into the true cost of health care, then the incentives will be accelerated for discharging, less testing, less procedures, that the patients may need.

Mr. KOLBE. Thank you.

One last quick question to Dr. Shapiro. The chairman of the Select Committee on Aging has introduced a bill, H.R. 1970, which addresses many of the things that we are talking about here today. One of its suggestions is with regard to Peer Review Organizations: It mandates that the PRO's would have to devote at least one-half of its efforts under the contract that they would have with the HCFA to quality assurance activities. Could you give us your reaction to that?

Dr. SHAPIRO. I think it is an essential part of our job, now, to focus our attention on quality issues. We really do not ever look at a hospital chart without addressing the question of quality. This happens whether we might be looking to see whether the DRG coding was appropriate. We still look at quality issues in every chart that we study.

Mr. KOLBE. But that can very often be a fairly narrow scope in the way you are addressing that question?

Dr. SHAPIRO. No. I would point out to you that there could not be too much emphasis placed on quality. I agree with you, there, but I would say with our present operation, we certainly do focus our attention on quality, and often times, if for instance, reviewing for one thing, we pick up quality items which we bring to the attention of physicians and the doctors—of physicians and the hospitals, pardon me.

Mr. KOLBE. Thank you, very much.

We will take a 5-minute break, while we get the next panel up here. And we will resume as quickly as possible, in 5 minutes.

[Whereupon, a brief recess was taken.]

Mr. KOLBE. The third panel that we have with us, are individuals from the State Medical Society, the Hospital Association, and the Home Health Care Medical Personnel of Tuscon.

The first individual we will hear from is Dr. Gary Henderson, who is the president of the Arizona State Medical Society, and a physician here in Tucson.

We also have Tom Plantz, who is chairman of the board of the Arizona Hospital Association, and also the head of Carondelet Health Care Systems, here in Tucson. So we have both organizations with their statewide presidents here in Tucson, and we are very pleased to have them with us today. And a third, is Robin Klaehn?

Ms. KLAEHN. Klaehn.

Mr. KOLBE. Klaehn. Robin Klaehn—I was right—Robin Klaehn who is a registered nurse, and is the Head of the Medical Personnel Pool of Tucson.

We will begin with Dr. Henderson.

PANEL THREE, CONSISTING OF DR. GARY HENDERSON, PRESIDENT, ARIZONA STATE MEDICAL ASSOCIATION, TUCSON, AZ; TOM PLANTZ, CHAIRMAN, BOARD OF DIRECTORS, ARIZONA HOSPITAL ASSOCIATION; AND ROBIN A KLAEHN, REGIONAL ADMINISTRATOR FOR MEDICAL PERSONNEL POOL IN ARIZONA

STATEMENT OF DR. GARY HENDERSON

Dr. HENDERSON. Thank you very much.

I am glad to be here today, to represent the medical society, and I have prepared a series of remarks to the questions that were asked of the Arizona Medical Association.

I will try to just give you a few highlights of what I had to say in my testimony, and try to make this as short as possible. I realize the hour is getting somewhat late.

I would first like to say that the State medical association has not been dealing with the DRG issue in a big way, and one of the things that we have really been dealing with, is something that probably is not as germane to this panel, is the malpractice issue.

I just mention that to say that one of our concerns in the medical association is in that particular area, and we are directing a lot of our attention. So that, when I got the call to appear before the committee, today, I did not have as much knowledge about DRG's as I might have. I am certainly more knowledgable about the malpractice issue. That is something that I think affects the practice of medicine and the concerns about the medical profession in the future.

It is also very difficult to express how deeply the physicians feel about the DRG issue, and I may not be as good at expressing it as I might be, but I will try to tell you that, sometimes, we feel that the DRG system will in fact drive a wedge between the hospitals and the physicians. Yet, so far, to the best of our knowledge, it has not occurred in this State.

We have—at the hospital where I practice—we have a DRG subcommittee. They are paid by the hospital. I asked the chairman of that committee, before I appeared today, if in fact that, to his knowledge, it ever happened, and he said, no. I think we have the

opportunity of seeing that in the future. We are concerned about it. We can see that, if, in fact, a patient has a certain amount of days and a certain amount of money allotted for their admission, and the money is used up, there is going to be concern on the part of the hospital to try and get that stay terminated.

We think that that will impact upon the medical profession, as well as on the patient. We are concerned about it. The physicians worry about the malpractice issue in that context. So far, we again have not found that that has been a problem. We are worried about that for the future.

I would try to just make some positive comments about what we can do, and I think one of the things that has come out in the testimony, today, is that there is a need to collect more data. As I come to you before the presentation today, I do not have the data that I really need. And it is hard for me to poll the 3,400 members of the medical association, and get the data that we need. We need a way for the physicians, as well as the elderly, as well as the hospitals, to give us more data on—if there are any abuses of the system, and is there a way that we can know about that. If people are being discharged early, there is not a good place that I can go to find that out. I think the medical association would be happy to participate in some way to collect that data.

The other thing that I thought has been mentioned and would be a positive comment, too, would be to consider some way, some sort of stepdown unit. If we have a patient, as in the first panel, who did not feel that they needed to, or they could go home—and believe me we are sympathetic to those kinds of problems—is there some way to build into the system, so that we have a step down unit, so that the patient could go there for a day or two, until things could be worked out better. I do not know that that can be built into the system, but at least that is a way in our minds, so if we have an outlet to put people out of the acute care setting, into something that is not a nursing home or home health care, but something that is in fact something of less care, and I certainly agree that there should be some sort of mechanism to gauge the severity of illness.

We see people that have, in my speciality, that have gallbladder disease, that are very very sick. They are septic; and they come in with lowered blood pressure. We have all sorts of problems with people that have acute gallbladders, but there is no provision—to the best of my knowledge—to gauge the severity of illness. And we can sometimes get them out under the DRG system in the amount of time that we are allotted, but I do think that we second the motion on this severity of illness context.

I was also somewhat surprised to find out how poorly we are reimbursed for outliers. Outliers means that you fall outside of the DRG classification. I guess that that is built into the system. I do not know that that could be changed, but if you have a case that is very difficult, that falls outside of the DRG system, the mechanism to reimburse the hospital is quite low, and I do not know that that can be changed, but it certainly—if you reimburse at 30 percent of cost of outlier days, that certainly does not seem fair. I may not be absolutely accurate in that, but this is some of the information that I have been given.

More than anything else, our concern from the medical society is to build quality into the system. We feel that maybe, maybe the DRG system is not building the quality into it that it should, and that the bottomline mentality is the real area of concern, and not the quality. We feel that the physician has, in the past, been free to sit by the bedside, make the decisions for the patient, not in the back of his mind knowing that there might be a cheaper way but a less better way, instead, of having to go the cheaper way to really give them the absolute best quality. And in the future you can see that there might be an effort to build in from the hospital standpoint, and even as you are thinking of the physician, maybe we can do it a cheaper way, that is not as good. We certainly endorse lowering medical care costs, but we do not endorse doing it cheaper just for the sake of doing it cheaper. We believe that quality is the bottomline issue from the standpoint of the medical association.

And as a last comment, it has been estimated that a lot of the rural hospitals, or at least some of the hospitals, might have to close down under the DRG system, at least the reimbursement would force them into a setting so that they could not stay in business, and having seen some of the hospitals in Arizona under attack from various reasons, it would certainly seem to us, as physicians, that some of the communities, if they were in danger of losing a hospital, what a tragedy that would be.

Thank you, very much.

[The prepared statement of Dr. Henderson follows:]

PREPARED STATEMENT OF DR. GARY HENDERSON

The following are the responses of the Arizona Medical Association to your questions in regard to testimony which will be delivered to the Subcommittee on Health and Long-Term Care at St. Joseph's Hospital Auditorium on September 14, 1985.

I am enclosing a copy of a special article from the publication Arizona Medicine, entitled "Medicine: The Death of a Profession", by Leonard Peikoff.

First of all, I would like to say that it is difficult to poll the 3,400 members of the Arizona Medical Association and totally reflect their thoughts regarding the prospective payment reimbursement system and its effect on the elderly in our state. I will try to reflect their concerns. First of all, the DRG system is not totally implemented as far as federal reimbursement for Medicare patients, and may be somewhat premature to make a total judgment regarding the system at the present time. As regards question—

1. a. (i) I believe that the overall trend across the country, and especially more specifically, to Arizona, is a dramatic attempt on the part of the physicians to reduce medical care costs. This is reflected in the hospital census in the hospitals of Arizona and it is true that the length of stay statistics show a drop, and also the number of admissions show a drop in Arizona. We feel that this does not reflect simply the impact of DRGs as much as it does the concern on the part of the medical community to try to lower health care costs. Certainly the efforts to justify all hospital admissions was in place well before the implementation of DRGs. I think it would be somewhat in error to feel that the dramatic change in numbers of hospital admissions and their length of stay would be directly related to the institution of prospective pricing reimbursement system. Physicians have been under rather intense scrutiny by hospital utilization review committees to justify the reason for their patients hospitalizations and this occurred long before the PPS system. As regards specifically 1.a., I polled several hospitals in the state from the perspective of DRG Subcommittees, and the best that we can determine, there has been no pressure from the hospitals to discharge patients earlier under the DRG system. The physicians of the state are quite aware of the PPS system and are trying to cooperate in every way possible to make the system work. There is certainly a degree of silent pressure which physicians exert on themselves to be aware of the cost ramifications of their patients admission and try to work within the DRG criteria which are usually outlined for their patients after they are admitted to the hospitals. If we

feel indeed the point in the future that the hospitals, or the representatives of the hospital could put pressure on the physician to produce a more cost-effective admission is one of the great dangers of the system. If there is activity on the part of the hospitals on the physicians to discharge patients because of cost reimbursement, I feel this is an area that would be taken up individually by the physicians of the medical staff and also would be an item of concern for our Medical Society.

1. a. (ii) It appears improper to assume that the decline in length of hospital stay particularly identifiable in the West as due to DRGs. Patients throughout the country are aware of rising hospital costs and are making efforts to seek early discharge with the promise of home-care and other ancillary levels of assistance. While DRGs have undoubtedly increased awareness, there does not appear to be any empirical proof that they have led in fact to shorter length of stay for Medicare patients in Arizona. The greatest problem we have is that the primary focus has now shifted from quality of care to the cost and length of care with quality becoming a secondary factor. Patients live longer and technology improves, it is not a correct assumption that it will be easier to discharge patients earlier, i.e., unlike manufacturing plants where new technologies cut down on costs, new technology often allows the treatment of disease which heretofore was untreatable, and in essence adds to medical expense.

1. b. We believe that the jury is still out on the entire DRG system. If physicians become comfortable with this system and do not feel they are being compromised in the level of quality of care they deliver, then they will continue to cooperate. However, we sense a growing discontentment on the overwhelming focus of the cost as a primary factor, and believe that many people will, over the long haul, resist the system which changes the primary attention from quality to cost.

1. c. At this point the process seems to be rather labor-intense. The success of the DRG system at this point is difficult for us to judge. Again, with the federal portion of the DRG reimbursement in an operation, we feel that it may be premature to judge the success or failure of the system. At the present time it does seem to be working. The statistics seem to be in favor of the DRG system. We have concerns that the reimbursement may change in the future. Physicians are concerned that they may be asked to be even more circumspect as to the number of days allowed for each particular illness, and that the standards may change so that patients are asked to in fact be discharged even quicker. Some of the comments which have been made from some of the hospital DRG subcommittees have been oriented to the heavy labor intensity of the process and the ever-reliance on computerization, and the expense of the whole process.

2. a. Informal contacts from various physicians around the state substantiate the fact that patients are being discharged quicker, and are sicker. There are some physicians however, do not totally agree with this. Again, I think the cooperation of the physicians and the elderly of the state of Arizona is quite remarkable, in trying to make the system work. The aging population is growing in Arizona at a rather rapid rate. At the last count 40% of all hospital days were related to Medicare and physicians are extremely concerned about this financial burden this puts on their non-Medicare patients. We know from personal experience the pressure is there to get Medicare patients in and out of the facility as quickly as possible. We do not have comprehensive statistics which can document either greater mortality morbidity rate as a result of premature discharge.

2. b. We think there should be greater emphasis on allowances for outliers and abnormal conditions which often present themselves when dealing with the elderly. We feel that the categories of the DRG groupings do not allow for different levels of sickness for the same conditions, and that indeed two patients with the same diagnosis may reflect a different level of need as regards the medical care. The DRG system is not able to take this into account. The DRG system itself may be rigid to accommodate the vast complications which are inherent in treating elderly patients. We would like to suggest that some type of routine flexibility should be looked at in terms of being incorporated into the system. (However, you need to realize this will specifically defeat the primary purpose of a fixed fee for a fixed diagnosis.

3. a. The main problem which I believe the Medical Association is concerned with regarding DRG's is that the focus has publicly changed from a quality of care to length and cost of care. It does not take great philosophical thinking to realize that cost, length, and quality are all very interrelated and in many instances if the primary factor is fixed cost, simple algebra will show that quality will suffer.

3. b. I do not at this time have specific examples of the effect of DRG's on quality of care. I am hopeful that some of the physicians and other people I will be talking to prior to the actual hearing will be able to provide me with concrete examples which I will pass on to you.

3. c. Not knowledgeable on the specifics at this time.

4. a. It would be my opinion that the Medical Association would support all efforts to provide appropriate post-hospital care which would facilitate the structured and intelligent discharge of patients into an appropriate secondary level of care. In my conversations with various physicians in the State, there seems to be a need for a somewhat step-down unit. Could there be a level of care somewhat between the hospital and the nursing home in which patients who do not fulfill the DRG criteria could be cared for? Certainly there are patients whose level of care is not appropriate for the nursing home or for home health care who could be provided for in a different setting. Perhaps the hospitals of the State have explored the possibility of converting some of their beds into step-down units in order to accomplish care for patients who would fit some specific criteria. We would also support the issue of upgrading nursing home care and the reimbursement of nursing home care and specifically perhaps an area of nursing home care could also address the issue of the step-down unit. We would again support the efforts to expand coverage of nursing home care for Medicare patients. We have also been aware of the issue that home health agencies could perhaps have a tendency to perpetuate care for their own sake and do not always assist patients in their post-hospital recovery.

5. Based on everything that I have said, I believe that our positions should be to support all efforts that ensure quality of care for our patient. We are not sure that there can be meaningful sophisticated quality assurance mechanism coupled with a strict DRG system. I believe all efforts at analyzing the effect of DRG's should be focused on the quality so that trade-off between cost savings and morbidity and mortality rates can be closely correlated. If the Medicare system is saving money because patients are going home sicker and dying early, one has to seriously question if it is really doing anything at all. It is clear, however, that the DRG system is here to stay until it is proven to support the issue of quality or it is found to be totally not effective, in which time we will be confronted with some other system. Given this reality, it is hard to come up with concrete changes of a major nature which will make the system work substantially smoother. There are many things which can be said from the Medical Association's standpoint about the DRG system and a perspective PPS reimbursement in regards to the overall effect on the medical profession of our country. There are certainly a great deal of concerns from our standpoint as to the profound changes that it will effect on the practice of medicine.

This completes my written testimony. I look forward to seeing you on September 14.

Special Article

Medicine:
The Death of a Profession

Leonard Peikoff

Leonard Peikoff is a professor of philosophy who has taught at Hunter College, Long Island University, and New York University. Dr. Peikoff, Ayn Rand's long-time associate and literary executor, is the author of *The Ominous Parallels: The End of Freedom in America* and the editor of *The Early Ayn Rand*. He lectures throughout the country on Ayn Rand's philosophy of Objectivism. Reprinted in *Arizona Medicine* with the permission of the copyright holder, Dr. Leonard Peikoff. Copies of the complete lecture are available for $2.50 each from *The Objectivist Forum*, P. O. Box 5311, FDR Station, New York, New York 10150.

[*This lecture was first delivered on April 14, 1985 at the Ford Hall Forum in Boston.*]

One day, when you are out of town on a business trip, you wake up with a cough, muscle aches, chills, and a high fever. You do not know what it is, you start to panic, but you do know one action to take: you call a doctor. He conducts a physical exam, takes a history, administers lab tests, narrows down the possibilities. Within hours, he reaches a diagnosis of pneumonia and prescribes a course of treatment, including antibiotics. Soon you begin to respond, you relax, the crisis is over. Or: you are getting out of your car, you fall and break your leg. It is a disaster, but you remain calm, because you can utter one sentence to your wife: "Call the doctor." He proceeds to examine your leg for nerve and blood vessel injury, he takes X-rays, reduces the fracture, puts on a cast; the disaster has faded into a mere inconvenience, and you resume your normal life. Or: your child comes home from school with a stabbing pain in the abdomen. There is only one hope: you call the doctor. He performs an appendectomy—the child recovers.

We take all this completely for granted, as though modern drugs, modern hospitals, and modern doctors were facts of nature, which always had been there and which always will be there. Many people today take for granted not only the simpler kinds of medical intervention, such as the ones I just mentioned, but even the wonder cures and wonder treatments that the medical profession has painstakingly devised—like the latest radiation therapy for breast cancer, or the intricate delicacy of modern brain surgery, or such a breathtaking achievement as the artificial-heart implants performed by Dr. William C. DeVries. Most of us expect that the doctors will go on accomplishing such feats rountinely, steadily removing pain and thus enhancing the quality of our life, while adding ever more years to its quantity.

America's medical system is the envy of the globe. The rich from every other country, when they get sick, do not head for Moscow or Stockholm or even London any more; they come here. And in some way, despite the many public complaints against the medical profession, we all know this fact; we know how good our doctors are, and how much we depend on their knowledge, skill, and dedication. Suppose you had to go on a six-month ocean voyage, with no stops in port, with ample provisions and sailors, but with only one other profession represented on board in addition, and you could decide which it would be. Would you ask for your lawyer to come along? your accountant? your Congressman? Would you dare even to ask for your favorite movie star? Or would you say: "Bring a doctor. What if something happens?" The terror of having no answer to this question is precisely what the medical profession saves us from.

I am not saying that all doctors are perfect—they are not; or that they all have a good bedside manner—they do not; or that the profession is free from flaws—like every other group today, the medical profession has its share of errors, deficiencies, weaknesses. But these are not my subject tonight, and they do not alter two facts: that our doctors, whatever their failings, do give us the highest caliber health-care in world history—and that they live a grueling existence in order to do so.

I come from a medical family, and I can tell you what a doctor's life is like. Most of them study non-stop for years in medical school and then work non-stop for the rest of their life. My own father, who was a surgeon, operated daily from 7 a.m. until noon and then made hospital rounds; from 2 to 6 p.m., he held office hours. When he came home for dinner, if he did, the phone never stopped ringing—it was nurses asking instructions, or doctors discussing emergency cases, or patients presenting symptoms. When he got the chance, usually late at night or on Sundays after rounds, he would read medical journals (or write for them), to keep abreast of the latest research. My father was not an exception. This is how most doctors, in any branch of medicine, live, and how they work.

The profession imposes not only killing hours, but also continuous tension: one way or another, doctors deal all the time with *crisis*—with accidents, disease, trauma, disaster, the imminence of death. Even when an ailment is not a mortal threat, the patient often fears that it is, and he must be reassured, nursed through the terror, even counseled psychologically by the physician. The pressure on the doctor never lets up. If he wants to escape even for the space of a single dinner on the town, chances are that he cannot: he will probably get beeped and have to rush to the emergency room just as the entrée is being served.

The doctor not only has to live and work in such a

pressure cooker, he has to *think* all the time—clearly, objectively, scientifically. Medicine is a field that requires a vast fund of specialized theoretical knowledge; to apply it properly to particular cases, the doctor must continuously make delicate, excruciatingly complex decisions. Medical treatment is not usually a cut-and-dried affair, with a simple, self-evident course of action: it requires the balancing of countless variables; it requires clinical judgment. And the doctor must not only exercise such judgment—he must do it fast; typically, he has to act *now*. He cannot petition the court or his client or any employer for a postponement. He faces daily, hourly, the merciless timetable of nature itself.

What I personally admire most about doctors is the fact that they live this kind of life not out of any desire for altruistic self-sacrifice, but *selfishly*—which is the only thing that enables them to survive it. They love the field, most of them; they find the work a fascinating challenge in applied science. They are proud men, most of them, with an earned pride in their ability to observe, evaluate, act, cure. And thank God, they expect to be rewarded materially for their skill; they want to make a good living, which is the least men can offer them in payment for their achievements. The make that living, as a rule, by standing on their own, not as cogs in some faceless, government-subsidized enterprise, but as entrepreneurs in private practice. In this regard, the doctors are among the last of the capitalist breed left in this country. They are among the last of the individualists that once populated this great nation.

Ladies and gentlemen, if I knew nothing about today's world but the nature of our politicians and the philosophy represented by the medical profession, I would predict an inevitable clash, a catastrophic clash, between the two: between the government and the doctors. On purely theoretical grounds, I would predict the destruction of the doctors by the government, which in every field now protects and rewards the exact opposite of thought, effort, and achievement. This evening, I want to tell you that this catastrophe is actually taking place, and in what manner, and how it will affect your future as well.

To understand what is happening in medicine today, we must go back to the beginning, which in this case is 1965, the year when Medicare and Medicaid were finally pushed through Congress by Lyndon Johnson. Medicare, as you may know, covers most of the medical expenses of those over 65, whatever their income. Medicaid is a supplemental program for the poor of any age.

Those of us who opposed the Johnson plan argued at the time that government intervention in medicine is immoral in principle and would be disastrous in practice. No man, we claimed, has a *right* to medical care; if he cannot pay for what he needs, then he must depend on voluntary charity. Government financing of medical expenses, we argued, even if it is for only a fraction of the population, necessarily means eventual enslavement of the doctors and, as a result, a profound deterioration in the quality of medical care for everyone, including the aged and the poor.

The proponents of Medicare were unmoved by any arguments. Altruistic service to the needy, they said, is man's duty. It is degrading, they said, for the elderly to be dependent on private charity; a "means test" is incompatible with human dignity. Besides, they added, the government would not dream of asking for any control over the doctors or over their methods of patient care. All we want the state to do, they said, is pay the bills.

Well, it is now 1985. Let us look at what actually happened.

The first result of the new program should have been self-evident. Suppose we apply the same principle to nutrition. Suppose President Johnson had said: "It is unfair to have to pay your own food and restaurant bills. Men have a right to eat. Washington, therefore, will pick up the tab." Can you project the results? Can you imagine the eating binges, the sudden mania for dining out, the soaring demand for baked peacock tongues and other gourmet delicacies? Do you see Lutece and the "21" Club becoming nationally franchised and starting to outdraw McDonald's? Why not? The eaters do not have to pay for it. And the food industry, including its most sincere members, is ecstatic; now that the money is pouring from Washington into the grocery chains and the restaurants, they can give every customer the kind of luxury treatment once reserved for millionaires. Everybody is happy—except that expenditure on food becomes so great a percentage of our GNP, and the drain on the Federal treasury becomes so ominous, that every other industry starts to protest, and soon even the bureaucrats begin to panic.

This is what happened to medical spending in the United States. The patients covered by the new programs no longer had to pay much attention to cost—that was the whole purpose of the programs. And the health-care professionals in the beginning were generally delighted. Now, many of them felt, the sky is the limit, and they proceeded to build hospitals, purchase equipment, and administer tests accordingly. Medical expenditures in the U.S. were 4.3% of GNP in 1952; today they are about 11%, and still rising. Medicare expenditures doubled from 1974 to 1979, doubled again in 1984, and are expected to double again by 1991, at which time, according to most current estimates, the Medicare program will be bankrupt. Something, the government recognized, has to be done; we are going broke because of the insatiable demand for medical care.

The government did not decide to cancel its program and return to a free market in medicine—when are disastrous government programs ever canceled? Instead, it did what governments always do: it decided to keep the programs but impose rigid controls on them. How? The first step was a campaign to force hospitals not to spend much on Medicare patients, no matter what the effects on the health of those patients.

We will no longer, officials said, pay hospitals a fee for each service they render a Medicare patient. That method of payment, they said, simply encourages

spending. Instead, we will pay according to a new principle, DRGs. Remember those letters: DRG. They represent the first major assault by the government against the doctors and their patients. It is not yet the strangulation of the medical profession. But it *is* the official dropping of the noose around their necks.

DRG means "diagnosis-related group." According to this approach, the government has divided all ailments into 468 possible diagnoses, and has set in advance a fixed, arbitrary fee for each; it will pay a hospital only what it claims is the average cost of the ailment. For example, for a Medicare patient in the Western Mountain region who is admitted to a hospital with a heart attack and finally recovers enough to go home, the government now pays the hospital exactly $5094—no more and no less. And it pays this amount *no matter what the hospital actually does for the patient*, no matter how long his stay or how short, no matter how many services he requires or how few. If the patient costs the hospital more than the government payment, the hospital loses money on him. If he costs less, the hospital makes a profit.

Let us pursue the heart-attack example for a moment. Here is a fictional story now in process of becoming reality around the country. A man suffering from severe chest pains is taken by ambulance to the hospital. He receives certain standard tests, including a cardiogram, then is moved to the Intensive Care Unit, where his vital signs are continuously monitored. His doctor thinks that in this instance a further test, an angiogram, is urgently indicated; this test would outline the arteries of the heart and indicate if one is about to close off, an event that could be fatal. The hospital administrator protests: "An angiogram is expensive. It costs up to $1000, about 20% of our total fee for this man, and who knows what else he's still going to cost us? You can't prove this test is necessary. Let's wait and see." The test is not given. Maybe the patient lives, maybe not. Several days later, the administrator comes to the doctor: "You've got to get this man out of the ICU. It's costing almost $800 per day, and he's been there now for five days. What with everything else, we've already spent almost the whole payment we get for him." The doctor thinks that the patient still desperately needs the specialized nursing available only in the ICU. The administrator overrules him. "There's an area of judgment here," he says. We'll just have to take a bit of a chance on this case."

Or: the doctor decides that the patient is an excellent candidate for remedial heart surgery; a by-pass operation, he thinks; would probably prolong the man's life considerably while relieving him of pain. But the man, after all, is elderly and the operation would involve a lengthy hospital stay. "Let's try a more conservative treatment first," the administrator says, "let's give him some medication and wait and see." Again, maybe the patient lives, maybe not.

Let us say that he lives and goes back to the regular ward in the hospital. He still feels very weak, and the doctor does not think he is anywhere near ready to be discharged. But the $5094 has long since been spent, and the administrator starts to wonder aloud: "Maybe this man could manage somehow at home. In any event, he's eating us alive—get him out of here." Maybe the patient will survive at home, maybe not.

Do you see the thrust of the system? If the hospital does relatively little for the patient, it makes money; if it provides an extensive range of services, it loses heavily. The best case from its viewpoint is for the patient to die right after admission: the hospital still gets the full fee. The worst case is for him to survive with complications and require a lengthy stay—which is why some hospitals are now refusing to admit patients they fear will linger on too long.

I do not mean to suggest that our hospitals are now merely shrugging and callously withholding urgently needed treatment from Medicare patients. Today's hospitals and doctors do have integrity; most are continuing to do their very best for the patient. The point is that they have to do it now within the DRG constraints. The issue is not simply: treat the patient or let him die. The issue is: treat him how? At what cost? With what range of services, specialists, and equipment? With what degree of safety or of risk? This is the area where there is enormous room for alternatives in the quality of medical treatment. And this is the area that is now in the process of being slashed across the board for Medicare patients, the very people singled out by the liberals in the 1960's as needing better medical care.

To revert to our nutrition analogy: it is as though the government socialized eating out, then paid restaurants in advance only what it computed as the average cost per meal. There would then be a powerful incentive for restaurants to cut corners in every imaginable way—to serve only the cheapest foods in the smallest amounts in the cheesiest settings. What do you think would happen to the nation's eaters—*and its chefs*—under such a setup? How long could the chefs preserve their dedication to preparing haute cuisine, when the restaurant-owners, in self-preservation, were forced to fight them at every step and to demand junk food instead? The same answer applies to our doctors today.

There is now a new and deadly pressure on the doctors, which continuously threatens the independence and integrity of their medical judgment: the pressure to cave in to utterly arbitrary, DRG economics, while blanking out the effects on the patient. In some places, hospitals are now offering special financial incentives to the physician who averages out at relatively low cost. For example, the hospital might subsidize such a doctor's office rent or purchase new equipment for him. On the other hand, a doctor who insists on quality care for his Medicare patients and thereby drives up costs is likely to incur the hospital's displeasure. In the extreme case, the doctor risks being denied staff privileges, which means cutting off his major source of livelihood. Thanks to DRGs, a new conflict is in the offing, just starting to take shape: the patient vs. the hospital. Or, to put it another way, the conflict is: doctors vs. hospitals—doctors fight-

ing a rear-guard action to maintain standards against hospitals that are forced by the government to become cost-cutting ogres. How would you like to practice a profession in which half your mind is devoted to healing the patient, while the other half is trying to appease a hospital administrator who himself is trying to appease some official in Washington?

And remember that Medicare patients are not a small group. On the contrary, because of their age, they constitute a significant part of most doctors' practice. Medicare patients now make up about 50% of all hospital admissions in the U.S.

The defenders of DRGs answer all criticisms by saying that costs simply must be cut. Even under complete capitalism, they say, doctors could not give unlimited treatment to every patient. This is true, but it ignores two crucial facts. 1) It is *because* of government programs that medical prices have soared so high and are now out of reach of masses of patients. This was not true in the days of private medicine. The average American a generation ago could afford quality, in medicine as in every other area of life, without courting bankruptcy. 2) Even if a patient could not afford it, at least, in the pre-welfare-state era, he was told the truth: as a rule, he was told about the treatment options available, and it was up to him, in consultation with his doctor, to weigh the various possibilities and decide how to cut costs. But under the present system, the hospital not only has to cut services drastically—it is to its interest to conceal this fact from the patient. If he or his family ever learns that the angiogram he is not going to have, or the heart surgery, would make all the difference to the outcome of his case, he would immediately protest violently, insist on the service, even threaten to launch a malpractice suit. The system is rigged to squeezing every drop of quality out of medical care, so long as the patient does not understand what is happening. The patient does not know medicine; he relies on the doctor's integrity to tell him what services are available and necessary in his case—yet, increasingly, the hospitals must try to batter down that integrity. They must try to make the doctor keep silent and not tell the patient the full truth.

Under the new system, the patient is no longer a free man to be accorded dignity and respect, but a puppet on the dole, to be manipulated accordingly—while the doctor is transformed from a sovereign professional into a mere appendage and accessory, a helpless tool in a government-orchestrated campaign of shoddy quality and deception.

The government's takeover of medical practice is not confined to public patients; it is starting to extend now into the private sector as well. This brings me to the HMOs, which are now mushrooming all over the country.

HMO means "health-maintenance organization." It could also have been called BBM, for "bargain-basement medicine." In this set-up, a group of doctors, perhaps with their own hospital, offers prepaid, all-inclusive medical care at a cheap rate. For a fixed payment in advance, a payment substantially less than a regular doctor would charge, the patient is guaranteed virtually complete coverage of his medical costs, no matter what they are. The principle here is exactly the same as that of the DRG system: if the patient's costs exceed his payment, the HMO loses money on him; if not, it makes a profit.

Although HMOs are privately owned, the spread of these organizations is wholly caused by government. There were very few HMOs in the days of private medicine. As part of the government's campaign to lower the cost of medical care, however, Washington has recently thrown its immense weight behind HMOs, even going so far as to advertise nationally on their behalf and to give them direct financial subsidies.

How do HMOs achieve their low rates? In essence, by the DRG method—the method of curtailing services. In this case, however, the cuts in quality are even more sweeping, inasmuch as the HMO embraces every aspect of medical care, and not merely hospital costs. For example, HMO doctors do not generally have personal patients, nor does the patient generally have a choice of doctors or even necessarily see the same one twice—that is too expensive. The patient sees whoever is on duty when he shows up; the doctor gives up the luxury of following a case from beginning to end. Nor does the doctor have much time to spend with a given patient—HMOs are generally understaffed to save money; typically, there are long waiting lines of patients. Further, the doctor must obtain prior authorization of any significant expenditure from a highly cost-conscious administrator. The doctor may detect a possible abdominal tumor and request a CAT scan—in effect, an exquisitely detailed, 3-D X-ray. But if the administrator says to him: "It costs a lot. I don't think it's necessary," the doctor is helpless. Or he may find that the patient has an aneurysm, a weakening of an artery that is like a time bomb waiting to go off, and he may want to operate to remove it. But the administrator can reply: "These cases often go years without rupturing. Let's wait a while." Like the doctor under DRGs, the HMO doctor ultimately has to obey: he either keeps his costs within the dictated parameters, or he is out of work.

What kinds of doctors are willing or eager to practice medicine under these conditions? In large part, they represent a new breed, new at least in quantity. There is a generation of utterly unambitious young doctors growing up today, especially conspicuous in the HMOs, doctors who are the exact opposite of the old-fashioned physicians in private practice—doctors who want to escape the responsibility of independent thought and judgment, and who are prepared to abandon the prospect of a large income or a private practice in order to achieve this end. These doctors do not mind the forfeit of their professional autonomy to the HMO administrator. They do not object to practicing routine, cut-rate medicine with faceless patients on an assembly-line basis—so long as they themselves can escape blame for any bad results and cover their own tracks. These are the

new bureaucratic doctors, the MDs with the mentality, and the fundamental indifference to their job, of the typical post-office clerk.

I hasten to add that there are better doctors in the HMOs (and that some HMOs are better than others). As a rule, however, the better doctors in these organizations are mercilessly exploited. Being conscientious, the better men put in longer hours than necessary, trying to make up for the chronic understaffing. They do not give in meekly to arbitrary decrees on cost; but fight the administrator when they feel their own judgment is right. Increasingly, their professional life becomes a series of such fights, which makes them the heavies, hard to get along with and guilty of costing the HMO money—while their lesser colleagues capitulate to the system, do as they are told, and take things easy. Time after time, the better men step in to bail out such colleagues, struggling to correct their errors, clean up their messes, rescue their patients. At a certain point, however, the better doctors start to get fed up.

An HMO doctor in California, a qualified internist and a highly conscientious woman whom I know personally, told me the following story. "I was looking through a pile of cardiograms one day," she said, "and I saw one that was clearly abnormal. I knew that the man should be taken by ambulance to the emergency room for retesting and possible hospitalization. Then I thought: it's late Friday afternoon, and it's going to take an hour and a half, and I'm not being paid for the extra work, and who will know if I wait until Monday? I was tempted for a minute to drop the whole thing and go home, but then the remnants of my conscience made me get up wearily and telephone the patient. This sort of thing," she concluded, "happens all the time and not just to me, and often the doctor does simply look the other way." Do you see what happens under a system in which the doctor is penalized for his virtue or, at the least, is deprived of any incentive, spiritual or material, including pride in his judgment and payment for his work? Would you like your cardiogram to be in a pile on this new breed's desk? Yours is next—all of ours are.

The cancer is growing inexorably. The debased standards inherent in government medicine are now spreading to the whole of medical practice in the United States. The new medicine is not restricted to Medicare patients or to HMO members; it is soon going to engulf private doctors as well, even when they see their own private, paying patients. There are many reasons for this. The most obvious is the pressure from the health-insurance companies, such as Blue Cross and Blue Shield. Hospitals now are charging higher rates to private patients in order to recoup their losses on Medicare cases. As a result, the private insurance companies are screaming, and demanding that a DRG-type system be imposed uniformly, on all patients. They want private insurance policies from now on to pay only according to arbitrary, preset DRG rates, just as Medicare does now, which would put the total of medicine in this country—all patients, all doctors, all ailments—into the same category as the heart-attack patient we discussed earlier. His fate would become everyone's, and the standards of American medicine would simply collapse.

If this demand of the insurance companies surprises you, remember that there are no truly private health-insurance companies in the U.S. today. What we have, in essence, is a government-protected, government-regulated cartel in this field. And what the cartel wants is not more freedom, but more money by means of government favors, including stiffer government controls over medical costs.

The end of the Medicare road, in other words, is complete socialized medicine.

Now you can see the absurdity of the claim that state payment of medical bills will not affect the freedom of physicians or the quality of patient care. State funding necessarily affects and corrupts every private service. Communism, in fact, is essentially nothing more than state funding. The Soviets pretty much leave doctors, and everyone else, free to dream or fantasize within their own skulls; all the government does is fund everything, i.e., take over the physical means of every citizen's existence. The enslavement of the country, and thus the collapse of all standards, follows as a matter of course.

Now let me backtrack for a minute. I have been maintaining that the cause of our soaring health-care costs is government funding of medical care. Many observers, however, claim that the cause is something different: the rapid advances in medical technology, such as CAT scanners or the latest, most sophisticated disease-detecting instruments, the magnetic resonance imaging or MRI machines. Some people, accordingly, want to limit such technology or even abolish it. Let me answer this objection briefly.

Technology by itself does not drive up costs; in fact, it generally reduces costs as it improves the quality of life. The normal pattern, as exemplified by the automobile and computer industries, is: a new invention is expensive at first, so that only a few can afford it. But inventors and businessmen persevere, aiming for the profits that come from a mass market. Eventually, they discover cheaper and better methods of production. Gradually, costs come down until the general population can afford to buy. No one is bankrupted, everyone gains.

What creates national bankruptcy is not technology, but technology injected into a field by government decree, apart from supply and demand. That is what is happening in medicine today. State-of-the-art medical treatment—including new inventions or procedures that are still prohibitively expensive, such as liver transplants and long-term dialyses—is being financed by the government for the total population in the name of egalitarianism. The result is the unbelievable expenditures that are made routinely in our hospitals, far beyond most people's capacity to afford. These expenditures are particularly evident in regard to the terminally ill, who almost always fall under the umbrella of some government-supported insurance program. It has been estimated that 1% of our GNP is now spent on the *dying*

in their last weeks of life. Did you hear that? Or, looked at in another way: *one-half* of a man's lifetime medical expenses occur now in the last *six months* of his life.

In a free society, you yourself would have to make a choice: do you want to defer consumption, cancel vacations, forego pleasures year after year, so as to extend your life in the ICU by a few months at the end? If you do, no one would interfere under capitalism. You could hoard your cash and then have a glorious spree in the hospital as you die. I would not care to do this. It does not bother me that some billionaire can live months longer than I by using machinery that I cannot begin to afford. I would rather be able to make ends meet, enjoy my life, and die a bit sooner. But in a free society, you are not bound by my decision; each man makes and finances his own choice. The moral principle here is clear-cut: a man has a right to act to sustain his life, but no right to loot others in the process. If he cannot afford some science-fiction cure, he must learn to accept the facts of reality and make the best of it.

In fact, in a free society, the few who could afford costly discoveries would, by the normal mechanism, help bring the costs down. Gradually more and more of us could afford more and more of the new technology, and there would be no health-cost crisis at all. Everyone would benefit, no one would be crushed. The terminally ill would not be robbing everyone else of his life, as is happening now, thanks to government intervention; the elderly would not be devouring the substance of the young.

Well—to return to my main theme—have I now covered, at least in essence, the way in which government is wrecking the practice of medicine and tightening the noose around the doctors' necks? I have barely scratched the surface. For example, I have not even mentioned the formal introduction of the principle of collectivism into medical practice—of committee-medicine as against individual judgment. This is exemplified by the flourishing PROs in our hospitals, the Professional Review Organizations, which act to oversee and strengthen the various DRG controls. PROs are committees of doctors and nurses established by the government to monitor the treatment of Medicare patients, and especially to cut its cost—committees with substantial power to enforce their arbitrary judgments on any dissenting doctor. These committees are the equivalent, in the Medicare system, of the HMO administrators, and have potentially the same kind of all-emcompassing power to forbid hospital stays (along with the associated tests and surgical procedures), even when the admitting doctor thinks they are required.

Nor have I yet mentioned CONs, or Certificates of Need. Since the government regards anything new in the field of medicine as potentially expensive, a hospital today is prohibited from growing in any respect, whether we speak of more beds or new technology, unless the administrator can prove "need" to some official. Since "need" in this context is undefined and unprovable, the operative criterion is not "need" at all, but pull, political pull. Under this program, the government last year denied Sloan-Kettering, the famous New York cancer hospital, permission to purchase an MRI machine, because another New York hospital already had it. Later, the government backed down in the face of the resulting public uproar. But what about the hospitals that do not enjoy such fame or contacts, and that are inexplicably denied the right to acquire a new and crucial diagnostic tool? So far, the freeze on them is only partly effective. Doctors are still allowed to purchase new equipment for their own offices, which hospital patients now often use. But the government is fighting to close this loophole; it is on the verge of decreeing that private doctors in their own offices out of their own funds cannot purchase new equipment without a government certificate of "need." Here again, by the way, you can see how *your* care will be affected, even if you are not a Medicare patient. If your doctor or hospital is not allowed to have the equipment, you cannot benefit from it either. It isn't there. It doesn't exist.

Nor have I mentioned the hundreds—yes, hundreds—of other government interventions in medicine. In the space of a year, state legislatures alone recently enacted almost 300 pieces of health-cost containment legislation. One hospital in New York now reports to 99 separate regulatory agencies.

And I have not touched on what is perhaps the most demoralizing crisis in the field of medicine today, demoralizing to the doctors; the *malpractice* crisis. We must, however, pause on this one, because it illustrates dramatically, in yet another form, the lethal effects of government intervention in the field of medicine.

Medical malpractice suits have trebled since 1975. There are now about sixteen lawsuits for every hundred doctors. In addition, awards to plaintiffs today average around $330,000 and are steadily climbing. The effect of this situation on physicians is unspeakable. First, I have been told, there is fear, chronic fear, the terror of the next attorney's letter in the mail. Then there is the agony of drawn-out legal harassment, including endless depositions and a protracted trial. There is the exhaustion of feeling that one lives in a malevolent universe, and that every patient is a potential enemy. Always, there is the looming spector: a career-destroying verdict. And whatever the verdict, win or lose, there is the fact that *all* of the doctors, innocent and guilty alike, are paying for it. They are paying for the exorbitant awards in the form of unbelieveable insurance premiums—over $100,000 per year per physician in some places.

In response to this situation, doctors are forced to engage wholesale in what is called "defensive medicine," i.e., the performing of unnecessary tests or procedures solely in order to build a legal record and thereby prevent the patient from suing later. For example, I heard about the case of a man falling and bumping his head slightly. Since there was no evidence of any head injury, there was no basis, in the doctor's judgment, to order an expensive series of skull X-rays. But if he does not order it, he takes a chance: if, months or even years

later, the man should develop mysterious headaches, the doctor might be sued; he might be charged retroactively with negligence, since he ommitted a test that might have shown something that might have prevented the headaches. So the doctor has no choice; he has to order the tests to protect himself. By a conservative estimate, defensive medicine now accounts for about *one-third* of all health-care costs.

Since the medical profession did not suddenly turn evil or irresponsible in the last decade or so, we must ask what is the cause of the soaring lawsuits. The most immediately apparent answer lies in the law, which has now lost any pretense at rationality. The standards of liability are corrupt. Negligence, in any rational sense of the term, is no longer the legal standard. Today's standard, in effect, demands of the doctor not responsible care, but omniscience and omnipotence.

For example, if a doctor prescribes a drug that is safe by every known test, and years later it is discovered to have side effects undreamed of at the time, the doctor can be sued. Was he negligent? No, merely non-omniscient. If he treats a patient with less than the most expensive technology, whether the patient can afford it or not, he can be sued. "You open yourself to a malpractice suit," says an attorney in the field, "if you even give the *appearance* of letting financial considerations conflict with good patient care."[3] Or: if a baby has a birth defect that can be ascribed to the trauma of labor, the obstetrician may be sued for *not* having done a Caesarian, even though there were no advance indications in favor of one—because as one obstetrician puts it, people assume "that anything less [than perfection] is due to negligence."[4] This last statement actually reveals the operative principle of the law today, not of some crackpot left-wing radical, but of the *law*: the patient is entitled to have whatever he wishes, regardless of cost or means; it makes no difference what doctors know, or whether the money exists; the patient's desire is an absolute, the doctor is a mere serf, expected to provide all comers with an undefined "perfect care" somehow.

Do you see where this idea comes from? It is the basic principle that underlies and gave birth to Medicare. "You the patient," Washington said in the 1960s, "need do nothing to earn your medical care or your cures. From now on you need merely *wish*, and the all-powerful government will do the rest for you somehow." Well, now we see the result. We see the rise of a generation of patients (and lawyers) who believe it, who expect treatment and cures as a matter of right, simply because they wish it, and who storm into court when their wish is frustrated.

The government not only inculcates such an attitude, but makes it seem financially feasible as well, because Washington has poured so much money into the field of medicine for so long. How else could anyone afford the defensive tests, or the inflated medical prices necessary to help pay for the incredible malpractice awards? They could not have been afforded in a free-market context. In the days of private medicine, there was no malpractice crisis; there was neither the public psychology nor the irresponsible funding that it requires. But now, thanks to government, there is both. And there is also a large enough corps of unscrupulous lawyers who are delighted to cash in on the disaster, lawyers who are eager to extort every penny they can from conscientious, bewildered, and in most cases utterly innocent doctors—while grabbing off huge contingency fees for themselves in the process.

The only solution to the malpractice crisis is a rational definition of "malpractice," which would restrict the concept severely, to cases of demonstrable negligence or irresponsibility, within the context of objective definitions of these terms, taking into account the knowledge and the money available at the time. But this is impossible until the government gets its standards and its cash out of the medical business altogether.

Ladies and gentlemen, we are all kept alive by the work of man's mind—the individual minds that still retain the autonomy necessary to think and to function. In medicine, above all, the mind must be left free. Medical treatment, as I have said, involves countless variables and options that must be taken into account, weighed, and summed up by the doctor's mind and subconscious. Your life depends on the private, inner essence of the doctor's function: it depends on the input that enters his brain, and on the processing such input receives from him.

What is being thrust now into the equation? It is not only objective medical facts any longer. Today, in one form or another, the following also has to enter that brain: "The DRG administrator will raise hell if I operate, but the malpractice attorney will have a field day if I don't—and my rival down the street, who heads the local PRO, favors a CAT scan in these cases, I can't afford to antagonize him, but the CON boys disagree and they won't authorize a CAT scanner for our hospital—and besides the FDA prohibits the drug I should be prescribing, even though it is widely used in Europe, and the IRS might not allow the patient a tax deduction for it, anyhow, and I can't get a specialist's advice because the latest Medicare rules prohibit a consultation with this diagnosis, and maybe I shouldn't even take this patient, he's so sick—after all, some doctors are manipulating their slate of patients, they accept only the healthiest ones, so their average costs are coming in lower than mine, and it looks bad for my staff privileges . . ." Etc. Would you like your case to be treated this way—by a doctor who takes into account your objective medical needs *and* the contradictory, unintelligible demands of 99 different government agencies and lawyer-squads? If you were a doctor, could you comply with all of it? Could you plan for or work around or deal with the unknowable? But how could you not? Those agencies and lawyer-squads are real, and they are rapidly gaining total power over you and your mind and your patients.

In this kind of nightmare world, if and when it takes hold fully, thought is helpless; no one can decide by rational means what to do. A doctor obeys the loudest

authority. Or he tries to sneak by unnoticed, bootlegging some good health-care occasionally. Or he gives up and quits the field.

Now you can understand why the philosophy of Objectivism holds that mind and force are opposites—and why innovation always disappears in totalitarian countries—and why doctors and patients alike are going to perish under socialized medicine, if its invasion of this nation is not reversed.

Conservatives sometimes observe that government, by freezing medical fees, is destroying the doctors' financial incentive to practice. This is true enough, but my point is different. With or without incentive, the doctors are being placed in a position where they literally cannot function—where they cannot think, judge, know what to do, or act on their conclusions. Increasingly, for a man who is conscientious, today's government is making the practice of medicine impossible.

The doctors know it, and many have decided what to do about it. In preparation for this talk, I spoke to or heard from physicians around the country. I wanted to learn their view of the state of their profession. From New York to California, from Minnesota to Florida, the response was almost always the same: "I'm getting out of medicine." "I can't take it any more." "I'm putting every cent I can into my pension plan. In five years, I'll retire."

Such is the reward our country is now offering to the doctors, in payment for their life-saving dedication, effort, and achievements.

As to talented newcomers rising to replace the men who quit, I want to point out that medical-school enrollments are now dropping. Bright students today, says the president of the Mount Sinai School of Medicine, are "discouraged by the perception of growing government regulation of medicine."[3] Note that it is bright students about whom he speaks. The other kind will always be in ample supply.

Any government program has beneficiaries, who fight to keep the program going. Who is benefiting from the destruction of the doctors? It is not the poor. A generation ago, the poor in this country received excellent care through private charity, comparatively much better care than they are going to get now, under the DRG and HMO approaches. The beneficiary is not the poor, but only one sub-group among them: those who do not want to admit that they are charity cases, those who want to pretend that they are entitled to medical handouts as a matter of right. In other words, the beneficiary is the dishonest poor, who want righteously to collect the unearned and consider it an affront even to have to say "Thank you." And there is another beneficiary: the new 9-to-5, civil-servant doctor, the kind who once existed only on the fringes of medicine, but who now basks in the limelight of being a physician and healer, because his betters are being frozen out. And there is one more beneficiary: the medical bureaucrats, lobbyists, legislators, and the malpractice lawyers—in short, all the force-wielders now slithering out of their holes, gorging themselves on unearned jobs, money, fame and/or power, by virtue of having sunk their fangs into the body of the medical profession.

Altruism, as Ayn Rand has demonstrated, does not mean kindness or benevolence; it means that man is a sacrificial animal; it means that some men are to be sacrificed to others. America today is a textbook illustration of her point. The competent doctors, along with their self-supporting patients, are being sacrificed—to the parasites, the incompetents, and the brutes. This is how altruism always works. This is how it has to work, by its nature.

The doctors resent today's situation passionately. Many of them are ready to quit, but not to fight for their field—at least, not to fight in the manner they would have to, if they were to have a chance of winning. In part, this is because the doctors are frightened; they sense that if they speak out too loudly, they may be subject to government reprisals. Above all, however, the doctors feel guilty. Their own professional motivation—the personal, selfish love of their field and of their mind's ability to function—is noble, but they do not know it.

For ages they have had it pounded into them that it is wrong to have a personal motivation, wrong to enjoy the material rewards of their labor, wrong to assert their own individual rights. They have been told over and over that, no matter what their own desires, they should want to sacrifice themselves to society. And so they are torn now by a moral conflict and silenced by despair. They do not know what to say if they quit, or how to protest their enslavement. They do not know that selfishness, the rational selfishness they embody and practice, is the essence of virtue. They do not know that they are the servants of their patients, but, to quote Ayn Rand, "not slaves, like everyone else in a free society"—and they should bear that title proudly, considering the crucial importance of the services they offer.[4] If the doctors could hear just this much and learn to speak out against their jailers, there would still be a chance, but only if they speak out as a matter of solemn justice, upholding a moral principle, the first moral principle: self-preservation.

Thereafter, in practical terms, they—and all of us—could advocate the only solution to today's crisis: removing its primary cause—in other words, closing down Medicare. Reducing Medicare's budget is not the answer—that will simply tighten the DRG noose. The program itself must be abolished. In principle, the method is simple: phase it out in stages. Let the government continue to pay, on a sliding scale, for those who are already too old to save for their final years; but give clear notice to the younger generations that there is a cut-off age, and that they must begin now to make their own provision for their later medical costs.

Is there still time for such a step? The most I can answer is: in ten years, there won't be—that is how fast things are moving. In ten years, perhaps even in five, our medical system will have been dismantled. The best doctors will have mostly retired or gone on strike, and the government will be so entrenched in the field that

nothing will get rid of it.

If you are my age, you may sneak by with the rest of your lifespan, counting on the remnants of private medicine that still exist. But if you are like many of the faces I see out there—in your teens, twenties, thirties—then God help you! To you, I want to conclude by saying: find out what is going on in this field—don't take my word for it—and then act, let people know the situation, in whatever way is open to you. In particular, talk to your doctor. If you agree with the Declaration of Independence, tell him that he, too, comes under it; that he, too, is a human being with a right to life; and that you want to help protect his freedom, and his income, on purely selfish grounds.

If you are looking for a crusade, there is none that is more idealistic or more practical. This one is devoted to protecting some of the greatest creators in the history of this country. And it is also, literally, a matter of life and death—*your* life, and that of anyone you love. Don't let it go without a fight.

References

1. Arthur R. Chenen, "Prospective Payment Can Put You in Court," *Medical Economics*, July 9, 1984.
2. Allan Rosenfield, quoted in Susan Squire, "The Doctors' Dilemma," *New York*, March 18, 1985.
3. James F. Glenn, quoted in "Professional Schools' Enrollment Off," *The New York Times*, Feb. 10, 1985.
4. *How Not to Fight Against Socialized Medicine*," *The Objectivist Newsletter*, March 1963.

Briefly Noted

Marshall B. Block, M.D., Phoenix endocrinologist and editor of *Arizona Medicine*, has been named Medical Director of the new 15-bed Humana Hospital—Phoenix Diabetes Center.

Harold E. Gries, M.D., Peoria, is the new medical director at Pueblo Norte Nursing Center, Plaza del Rio, Peoria. Dr. Gries has served as head of the Department of Family Practice at Boswell Memorial Hospital.

Ronald P. Spark, M.D., President of the Pima County Medical Society, was the guiding force behind Tucson's Project Graduation campaign. The program enlisted the support of schools and young people in promoting a chemical-free graduation. Spark, a pathologist, said that last year, of the 91 Pima County teens who died, 35 were accidental deaths and most involved alcohol.

The growing problem of professional liability insurance was the topic of an American Medicine Association sponsored teleconference presented in cooperation with the Arizona Medical Association in Phoenix in June. Professional Liability Committee members who attended the teleconference were: **Drs. Earl J. Baker, Jack Brooks, William J. Mangold, William R. Myers, Edward Sattenspiel, William C. Scott, Loren Fritz Taylor,** and **Neil O. Ward.**

The Arizona Medical Association welcomes the following new member:

Active Members
Maricopa

Kenneth A. Brown, M.D.
Emergency Medicine
475 South Dobson Road, Chandler
University of Oregon - 1977

Marlin L. Dimond, M.D.
Plastic Surgery, Hand Surgery
4626 East Shea Boulevard, C280, Phoenix
George Washington University - 1975

Alexander M. Don, M.D.
Psychiatry
5757 West Thunderbird Road, Glendale
Medical School University of the Witwatersrand, Johannesburg - 1958

Patrick J. Donovan, M.D.
Hematology, Internal Medicine
7331 East Osborn, No. 300, Scottsdale
University of Nebraska - 1977

Kenneth M. Fisher, M.D.
Family Practice
2610 West Bethany Home Road
No. 202, Phoenix
University of Minnesota - 1979

John O. George, M.D.
Family Practice
12635 North 42nd Street
Paradise Valley
University of Pittsburgh - 1950

David G. Greenberg, M.D.
General Practice
755 East McDowell Road, Phoenix
University of California - 1979

Donna G. Horne, M.D.
Pathology
7400 East Osborn Road, Scottsdale
University of Minnesota - 1973

Michael S. Kappy, M.D.
Pediatrics, Pediatric Endocrinology
350 West Thomas Road, Phoenix
Universityof Wisconsin - 1967

Steven M. Linnerson, M.D.
Obstetrics and Gynecology
2204 South Dobson Road
No. 204, Mesa
University of Colorado - 1977

John D. Marshall, M.D.
Family Practice
4232 East Cactus Road, Phoenix
University of Toronto
Faculty of Medicine - 1977

Arnold H. Meyerowitz, M.D.
Family Practice
1402 South Mill Avenue, No. 2, Tempe
Medical School University of the Witwatersrand Johannesburg - 1973

Steven B. Perlmutter, M.D.
Ophthalmology
300 West Clarendon, No. 150, Phoenix
Washington University - 1980

Robin L. Prentice, M.D.
Anesthesiology
5060 North 19th Avenue
No. 103, Phoenix
University of Arizona - 1979

Harold L. Rekate, M.D.
Neurological Surgery
2910 North Third Avenue, Phoenix
Medical College of Virginia - 1970

Susan D. Scarla, M.D.
Emergency Medicine
1741 East Morten Avenue—B, Phoenix
University of Arizona - 1979

James M. Tillinghast, M.D.
Anesthesiology
7008 East Osborn Road, Scottsdale
University of Texas Medical Branch, Galveston - 1977

Address Correction:
Susan B. Hays, M.D.
Dermatology
9220 East Mountain View Road
Suite 213, Scottsdale
College of Medicine and Dentistry of New Jersey - 1980

Navajo
Mark I. Rons, M.D.
Internal Medicine
P. O. Box 848, Show Low
University of Arizona - 1978

Pima
Bruce K. Adams, M.D.
Emergency Medicine
6900 North Chaparral, Tucson
University of Minnesota - 1974
Dennis R. Bastron, M.D.
Anesthesiology
5200 East Grant Road
No. 602, Tucson
University of Iowa - 1964
Steven E. Calvin, M.D.
Obstetrics and Gynecology
839 West Congress Street, Tucson
Washington University - 1980
James Robert Cassady, M.D.
Therapeutic Radiology
Arizona Health Sciences
Center, Tucson
Harvard Medical School - 1963

John H. Finley, M.D.
Anesthesiology
5700 East Pima-E, Tucson
Creighton University - 1975
David I. Lapan, M.D.
Cardiology, Internal Medicine
1773 West St. Mary's Road, Tucson
University of California
San Francisco - 1974

Final
Eleanor A. Mokrane, M.D.
Obstetrics and Gynecology
1820 East Florence Boulevard
B, Casa Grande
University of Nevada School of
Medical Science - 1980

Yavapai
David A. Griesemer, M.D.
Neurology, Child Neurology
1022 Willow Creek Road
No. 104, Prescott
John Hopkins University - 1976
Ronald F. Whitney, M.D.
Urological Surgery
1003 Division, Prescott
Tufts University - 1972
Elaine Pearson Young, M.D.
Dermatology
300 South Willard
No. 104, Cottonwood
Northwestern University - 1967

Yuma
Pedro F. Almazan, M.D.
Family Practice
201 First Avenue, Yuma
Faculty of Medicine and Surgery
University of Santo Tomas - 1953
Louis K. Madison, M.D.
Radiology, Nuclear Medicine
2451 South Avenue, No. 7, Yuma
College of Medicine
and Dentistry
of New Jersey - 1976
Julio Zonis, M.D.
Neurology
1220 West 24th Street
No. 1, Yuma
University of Tel-Aviv - 1977

Service Members
Maricopa
Vimal V. Abhyanker, M.D.
Psychiatry
1424 South Seventh Avenue
Phoenix
University of Bombay - 1963
Vincent J. Russo, M.D.
Orthopedic Surgery
10250 North 92nd Street
Scottsdale
State University
of New York - 1948

Pima
Marlene Bluestein, M.D.
Internal Medicine
Veterans Administration
Medical Center, Tucson
State University of New York
at Buffalo - 1976

Resident Members
Maricopa
Hara P. Misra, M.D.
Sirirram Chandra Bhanj
Medical College
Utkal (India) - 1969

Student Members
University of Arizona
Thomas Goodheart

Affiliate Members
Maricopa
Marwin A. K. Lommen, M.D.
University of Pittsburgh - 1955

ArMA

President
Gary L. Henderson, M.D.

President-Elect
Neil O. Ward, M.D.

Vice President
Robert S. Hirsch, M.D.

Secretary
Richard L. Collins, M.D.

Treasurer
Mark Ivey, Jr., M.D.

Past President
Earl J. Baker, M.D.

Executive Vice President
Bruce E. Robinson

Publishing Committee
Marshall B. Block, M.D., Chairman
Earl J. Baker, M.D.
Burnell R. Brown, M.D.
George E. Burdick, M.D.
Richard L. Collins, M.D.
Kenneth B. Desser, M.D.
Jay S. Fleishman, M.D.
Benjamin K. Harris, M.D.
Jonathan M. Levy, M.D.
William B. McGrath, M.D.
Neópito L. Robles, M.D.
Jay W. Smith, M.D.
Volker K.H. Sonntag, M.D.
Sidney C. Werner, M.D.

Mr. KOLBE. Thank you, very much, Dr. Henderson.

We will next go to Tom Plantz, president of the Arizona Hospital Association. Tom?

STATEMENT OF TOM PLANTZ

Mr. PLANTZ. Thank you, Congressman Kolbe and Congressman McCain.

I am Tom Plantz, and I am representing the Arizona Hospital Association, of which I am the chairman of the board of directors.

I am here today representing literally 58 of our hospitals statewide, who are members of the Arizona Hospital Association. These hospitals, together, comprise approximately 10,000 of our inpatient beds here within the State, as licensed by the State of Arizona. On behalf of our association, I would like to extend a collective thank you for the opportunity to submit both the written testimony, earlier, and the opportunity, today, to comment verbally.

The written testimony, as you will find before you, is much longer than the few comments I am about to make. So, in keeping with Dr. Henderson's lateness of the hour, I will move very quickly.

The Hospital Association, for the record, has submitted that written statement, and it is before you, I believe.

Mr. KOLBE. And it will be entered into the record.

Mr. PLANTZ. Our member hospitals have identified several key issues of concern in the course of responding to the five issues, as defined in your initial letter, dated August 13, 1985, and through their input of those individual hospitals, combined with the involvement of the Hospital Association's councils on patient care and finance, which have met together in the last couple of weeks in Phoenix, we have identified some of these following issues, and urge your consideration, as we articulate them.

Significantly, they are as follows: With respect to the scope of PPS, prospective payment system reimbursement impact, in our review and evaluation of the impact of the DRG system on the elderly in Arizona, there needs to be more focus on the health care system in a broader sense and not just the role and activities of the hospitals, alone, or the physicians, alone. Each participant in the delivery of health care services should be considered in determining the overall impact of PPS.

These participants that I refer to include physicians, hospitals, certainly, nursing homes, home health care agencies, allied health professionals and social service agencies in the community. As an example, in this State, we have some 8,263 skilled nursing home facilty beds, and only about 910 of those are licensed under the State health department, and therefore only those 910 receive Medicare certification, and thus, Medicare will not pay for that skilled nursing care when those patients are admitted to those facilities. Indeed, a burden is added to the patients and the family at that time, a financial burden, particularly. These nursing homes, while good, I know are working hard to increase the standards so that that certification will come, and, yet, that is a dilemma, particularly for our elderly patients.

54-636 O - 86 - 3

Some other range of factors that I think are worth mentioning, although the PPS has a significant impact on the health care system, and the delivery of health care services relative to our hospitals, the effects of PPS are just one factor contributing to the changes occurring in the health care environment, today.

In Arizona, the health care providers have experienced the growth and popularity of outpatient surgical centers and outpatient treatment centers, as alternatives to inpatient care; we applaud that effort in the name of good patient care at lesser cost. In fact, as many of you know, Arizona was a pioneer in the development of this alternative care program. In addition, the Arizona Medicare experience, called AHCCCS and the elimination of the certificate of need statutes, have also contributed to the changing environment in the delivery of health care services in our State.

The point of what I am saying is PPS has had an impact and DRG's, yes, have had an impact but there are also many other factors that need to come into this equation as you make your evaluation.

With respect to modifications of this system, regarding some of the questions you have raised in your letters, this subcommittee review, I would hope, and others like it around the country, reveals that the PPS and the DRG system is working. The Arizona Hospital Association also believes that it is working, but that further tightening down of the financial reimbursement and/or a continued racheting down, if you will, by Federal Government, will eventually lead to a reduction in health care services—both accessibility and availability of those services for our elderly patients.

Further, if the system is determined to be working, additional change in the new incentives currently employed will again cause and create changes in provider behavior in response and reaction to a new set of ground rules, which may be counterproductive. In plain English, I would suggest respectfully that the system not be tinkered with too much; give it a chance to work.

In the determination of the effect and impact that PPS has had on such areas as quality of care, our Hospital Association believes that consideration must be given to clearly defining as difficult as it may be, such terms in the relationship to the elements to be measured regarding that issue of quality of care.

With respect to the need for additional regulations, as raised in your letter, our association supports the belief that there is no need to create and impose additional regulatory programs on hospitals or physicians, for the purpose of monitoring PPS. The basic system is in place. It needs time to work. It should not be significantly tampered with, in our judgment, but in support of our seniors, many of them whom we have heard from this morning, it needs refinements and flexibility so as to be more sensitive to individual needs and extenuating circumstances within those individual needs.

Our Hospital Association believes that greater coordination with other interested and effected parties needs to occur in the future development and implementation of PPS. As we have noted, the health care agencies, allied health professionals, and other social service agencies, within the community are all impacted as a result of the PPS. The effect of these parties, as well as hospitals, needs

to be coordinated to avoid lapses or gaps in providing the necessary resources and services to treat the population, the elderly population in need of health care. While our hospitals believe throughout the State that the care rendered during inpatient hospitalization is of good quality, we recognize, as was mentioned here this morning during the first panel, that the elderly patients particularly sometimes require other support resources once they are discharged from the hospital. That gets into the whole area of community agencies and home health care services. Not all those cases need to be taken care of in hospitals, and yet, the need is there on the part of the elderly.

Another participant in the health care delivery system, which is currently exempted from PPS and DRG programs, is the free-standing psychiatric hospital. The Association of Arizona Hospitals, whose membership includes six such psychiatric hospitals, would urge that the current exemption for such hospitals be maintained at least another 2 years to allow for the completion of studies to determine what prospective payment system would be appropriate for our free standing psychiatric hospitals in this State.

In closing, Congressmen, hospitals, we believe, are responding to the PPS, here in Arizona, in the manner in which the Department of Health and Human Services and the Health Care Financing Administration intended it. In other words, hospitals are responding to and working within the DRG system. However, PPS appears to be just one factor contributing to the changes occurring with the management and operation of our hospitals in delivering care and services. There are additional factors that have initiated or supplemented changes to or with the health care delivery system, such as growth of HMO's, particularly here in the community of Tucson, the health benefit redesign as brought about by business and industry and others, PPO's, IPA's, and the rest of the alphabet soup, all impacting on the question before the House.

The health care environment in this State, I believe everyone realizes in the last couple of years, has experienced significant change. Because of these changes, new opportunities have been created providing hospitals and other health care providers with greater flexibility to meet the need to deliver health care and health care services.

Hospital administrators, nurses and physicians, alike, are all concerned and sensitive to the issues expressed here this morning relating to cost, quality and accessibility and delivery. While we all believe that appropriate care is most always given in our hospitals at the hands of our physicians, we are quick to recognize that once the patient is discharged from our hospitals, oftentimes other levels of care and social services are necessary in the home setting.

The burden for care under PPS may well be shifting from the hospital setting to other community, social service agencies, and I think that is an important point to underscore.

The Arizona Hospital Association and its member institutions are ready and willing to work with your subcommittee, with the Congress to address the issues and hopefully find better solutions to these problems. They're our problems collectively.

Our goal with our physicians is quality patient care at a reasonable and affordable price and hospitalizations we all know are costly

and the Federal Government must continue to recognize that someone has to pay for the extra burden resulting from the goods and services consumed by our elderly patients. Those patients cannot bear the burden alone, particularly after being discharged from the hospitals, and our payment systems have failed to address that fully.

I am pleased to mention that our Hospital Association here in Arizona is taking a positive step this fall, 1985, when we cosponsor, with various senior citizen groups, and the American Hospital Association, a senior symposium to discuss, inform, and educate both hospitals and senior citizens, regarding the dilemma before us, the DRG's and the PPS payment system.

On behalf of the Arizona Hospital Association, Congressmen, we thank you for the opportunity to be with you this morning.

[The prepared statement of Mr. Plantz follows:]

PREPARED STATEMENT OF TOM PLANTZ; ARIZONA HOSPITAL ASSOCIATION

On behalf of the 58 member hospitals of the Arizona Hospital Association, I would like to extend our appreciation and gratitude to the Committee and specifically to Arizona's Representatives McCain and Kolbe for the opportunity to present the membership's statement on the impact of the prospective payment reimbursement system (PPS) on the elderly in Arizona. The 58 member hospitals of the Association include rural as well as urban hospitals, general acute-care and specialty hospitals (psychiatric and childrens), non-profit and for profit hospitals, and public as well as private hospitals. Collectively the Association's member hospitals account for 9,273 of the 10,952 hospital beds licensed by the State.

Pursuant to your letter of August 13, 1985, the Association has considered your request and in honor of that request prepared a response for inclusion in the hearing record.

ISSUE 1

One of the points made in favor of DRGs at the time of its adoption in 1983 was that the system would encourage shorter lengths of hospital stay. Earlier this year, the General Accounting Office, in a report to the Senate Special Committee on Aging, noted that "Recent data on the use of hospitals under Medicare appear to show that hospitals have in fact responded (to the PPS system) by reducing lenghts of stay".

a. How have hospitals in the state of Arizona responded to the implementation of the DRG system? Specifically:

(i) Has the average length of stay for Medicare patients in Arizona declined since the inception of DRGs?

(1) If so, by how much?

(2) Is this decline concentrated in certain specific DRG classifications? If so, which ones?

(ii) Presuming a decline in the lenght of hospital stay, does this trend have any medical significance which should be monitored by Congress, with consequent modifications to the DRG system?

b. What is the recent history of Arizona's rate of health care inflation?

(i) Do you attribute any impact on the rate of inflation to the use of the DRG system?

(ii) Do you foresee the DRG system serving successfully over the long-range in restraining the rise in health care costs?

(iii) Are there limits to how much the DRG system can be expected to hold down the rise in health care costs without compromising health care?

c. Arizona is in a unique position in that the state does not have a Medicaid program. Does the lack of Medicaid services have any impact, adverse or otherwise, on the success of the DRG program in our state?

d. Overall, how would you assess the success of the DRG system in Arizona?

RESPONSE 1

Relative to Issue 1 and its subparts, member hospitals of the Association have responded to the implementation of the DRG system generally as the hospitals were expected to respond. The PPS provides incentives to the health care providers to reexamine and evaluate the current delivery system(s). As predicted, once the pressure points changed, the suppliers of health care services did act accordingly and alerted or modified their individual approaches to the delivery of services to best accommodate their organizations and clientele.

Although aggregate data with respect to average length of stay (ALOS) for Medicare patients is still being tabulated by the State's fiscal intermediary (Blue Cross and Blue Shield), the ALOS for Medicare patients in Arizona appears to be declining in hospitals. In checking with individual hospitals within our membership, the ALOS for Medicare patients has declined between .5 and 1.5 days. However, it is worth noting that the ALOS for Arizona hospitals has been gradually declining over the past ten years. For example, the ALOS for hospitals in Arizona was 8.0 in 1976. The ALOS declined to 6.5 for 1982, 6.5 for 1983, 6.1 for 1984, and 5.9 for the first six months of 1985 as calculated by the Arizona Department of Health Services.

With the length of stay declining, the possible medical significance is an issue that should be considered by the health care provider community. However, the effect PPS is having on the delivery of health care and health care services has become evident. Because PPS has introduced a different set of incentives for the health care delivery system, health care providers are responding by intensifying efforts to treat patients for their specific ailment, illness or disease; by developing and offering treatment in less costly alternative settings, i.e. outpatient treatment centers and outpatient surgical centers; and by discharging inpatients to less costly settings to convalesce.

Although PPS has moved the health care delivery system and individual providers to become more economical and cost conscious, several issues might be noted for the Committee's consideration. First, just because the ALOS is declining does not mean that the consumption of resources to treat patients will in turn decline. Second, the financial incentives provided through PPS have moved the provision of services to less costly alternative settings. Because of this movement, the individuals who are admitted to hospitals as inpatients have a tendency to have higher acuity levels. Third, the impact PPS is having on the social services programs (as opposed to the strictly medical delivery system) is tremendous. As hospitals move to discharge patients sooner, the social services programs established to assist senior citizens and others in recuperating are experiencing pressure for additional resources to provide the necessary domestic, social and home health services and facilities for patients. Fourth, the PPS has initiated action by the health care provider to reassess the viability of services currently being provided and planned for the future. As a result, the potential problem of accessability and availability of services should be reviewed and considered. Because reimbursement and payment for health care services is moving to a prospective basis, the health care provider must start looking at and to services that are both needed and financially viable. This trend may particularly impact the delivery of health care services in rural Arizona.

The experience of the Peer Review Organization (PRO) in Arizona conducted by the Health Services Advisory Group (HSAG) also indicates that the ALOS is declining. Specific statistics to indicate the actual decline and specific DRG classifications are not yet available. Once figures are available from the PRO and the Fiscal Intermediary (Blue Cross and Blue Shield), we will share such information with the Committee.

Finally, another dimension which cannot be overlooked with respect to the inpatient utilization admission and discharge aspects under the PPS is the role of the physician. In Arizona a physician is responsible for admission and discharge of a patient. Because PPS reimbursement is directly affecting the hospital, hospitals through their medical staffs are working closely with physicians to respond to the program.

The recent history of Arizona's rate of health care inflation is considerably lower than the rates in prior years. In review of the data from the Arizona Department of Health Services, the average increase in rates and charges was 3.8 percent for all hospitals licensed by the State. The 1984 average increase is very favorably when compared to the preceding years' averages: 1983 (9.6 percent), 1982 (16.5 percent) and 1981 (15.2 percent). To date for 1985 the average increase in rates and charges is 5.8 percent.

The 1984 average increase, 3.8 percent, also compares very favorably with the United States' Consumer Price Index (CPI) Hospital Component, which was 7.0 percent.

Obviously some credit must be given to PPS/DRG system relative to the impact on the reduction in the rate of inflation. However, the degree and amount is yet to be determined. The PPS/DRG system may in fact over the long-range restrain the rise in health care costs, but only to the payor (U.S. Government) who utilize and beneficiaries covered under this system. The long-range benefits, if any, for restraining the rise in costs will in all probability be at the expense of the non-Medicare patients and payors, because of the cost-shift game. In other words, if HCFA continues to reduce or freeze their payment schedule, a greater portion of the costs of providing services and operating facilities will be borne by other payors.

Arizona is in a unique position in that the state does not have a traditional Medicaid program. However, the State has had in effect for approximately 3 years the Arizona Health Care Cost Containment System (AHCCCS) which is a Medicaid-funded demonstration program, where the payment system is based on capitation. Because this is an experimental program, the traditional rules and regulations applying to Arizona's situation relative to Medicaid do not necessarily apply. In fact, AHCCCS provides greater flexibility and latitude for the state to meld payment approaches and does not appear to impede the PPS.

To assess and measure the success of the DRG system in Arizona is a difficult task at best. It differs from hospital to hospital and as to the measure of success the program has had to date. If in fact the program's success is measured in the sense of making health care providers (hospitals) more efficient economically and cost conscious in the delivery of health care services, one would have to probably respond positively. The cause for such a positive response is characterized in general by the decline of hospital expenditures since the implementation of PPS. However, for some hospitals, the movement by HCFA to nationalize all the various standards and norms with respect to payment will have a differential impact on not only various regions throughout the United States but on those areas within a state with differences in geography, demographics and economic characteristics. However, the member hospitals of the Association do believe that the program has created a different and new set of incentives and responsibilities for hospital response. As a result, it appears that the slack within the health care delivery system has started to tighten up. In other words, the system is becoming more efficient operationally as well as economically.

ISSUE 2

Earlier this year, the Aging Committee received testimony from interested individuals and organizations, in particular visiting nurse associations and home health agencies, which reported that hospitals under DRGs are discharging patients "quicker and sicker."

a. What discharge planning procedures do hospitals have which assure that patients receive sufficient counselling prior to discharge?

(i) How well is this system functioning in Arizona?

(ii) Are improvements needed in order to assure that elderly patients are adequately provided for upon discharge from a hospital?

RESPONSE 2

As noted under Response 1, the Average Length Of Stay is declining, which would indicate that patients are being discharged "quicker." However, to discuss the issue of "sicker" is a medical analysis probably better considered by the physician community. More to the point regarding the specific issue of discharge planning, the hospitals have recognized and initiated actions to deal with the discharge planning process as a result of the PPS system. In fact hospitals are moving to initiate discharge planning activities almost at the outset of an individual admission to the facility. From a hospital stand-point, the discharge planning process/system appears to be working well within the hospital. However, there are areas that need to be enhanced and improved. As noted in Response 1, the demands being placed on the alternative settings for inpatients' to recuperate and convalesce such as home health agencies, nursing homes, visiting nurse services is increasing. In addition, the social service agencies such as the area agencies on aging are experiencing increased demand for services from discharged patients. Because of the increased demands for these services, such associations and agencies are in need of greater resources to meet the increased demand. Another aspect of the discharge planning

procedure that needs to be enhanced and intensified is the patient and family responsibility for certain activities and functions upon discharge.

Overall, it would appear that the resource most in need of increase rests with the assistance of non-skilled employees to be provided to discharged patients. As government reduces and limits the amount of dollars provided to hospitals for the care and treatment of patients, the health care community has responded to these financial incentives by discharging patients as soon as medically advisable. However, the dollars that are available to other organizations such as home health agencies, nursing homes, visiting nurse services, and social service agencies have not been proportionated increased although the pressure for such non-hospital expertise and services is increasing dramatically.

When analyzing the impact PPS is having on the health care delivery, it is critical that we look at the system from a broader viewpoint including not only the hospital perspective but that of the physician, home health agency, nursing home, etc.

Relative to the issue of "sicker" discharges, we discussed with the State PRO their experience with cases reviewed that might be judged potentially as premature discharges. At this point in time, the PRO acknowledges 12 such potential cases under consideration. Those 12 cases come out of a review experience (8/1/84 to 7/31/85) of approximately 40,000 discharges of which approximately 400 were reviewed due to the mandate to review all cases that were readmitted within seven days. It would appear that claims and stories about people being discharged "too soon" is a small fraction of the overall discharges under PPS in Arizona to date.

ISSUE 3

By law, the Department of Health and Human Services will be reporting to Congress on the issue of "quality care" under the prospective payment system.

a. What is the view of the Arizona Hospital Association on the quality of care issued under DRGs?

b. Can you provide the Subcommittee with any preliminary judgments on the impact of DRGs on quality of care?

c. Are there specific aspects of the DRG system relating to quality of care that the Hospital Association believes need attention?

RESPONSE 3

To address and express our views on the "quality of care" under PPS/DRGs is a difficult question to even begin to address. The term "quality care" has never really been clearly defined by HHS or HCFA. Although quality of care is hard to discuss without a clear definition, we do know that hospitals are experiencing patients with higher acuity levels (sicker patients) that are consuming resources at the same level if not more than before PPS/DRGs.

Another consideration relative to the quality of care under DRGs is the impact of advancements in technology and capital expenditures. As mandates have been created over the years for regulatory control of the purchase and distribution of new technology, it is hard to determine how the quality of care may have been improved if in fact technology was available without regulatory control. Because PPS provides a limit on the amount of reimbursement an institution will get for a patient, institutions are re-evaluating and assessing the introduction of new services, equipment with a keener awareness of the financial implications of such a purchase.

The severity of illness within the PPS/DRG system needs to be explored and reasonable and specific measurement tools to determine the severity of the illness and the associated resource consumption be developed.

Quality of care is also potentially impacted by any PPS/DRG effect on the availability and accessability of services to the population. As previously discussed, this potential problem may be particularly applicable in rural areas. As the financial constraints on health care providers tighten, certain current and planned services in rural areas may have to be reassessed. In turn, individuals seeking such services may have to travel greater distances to access needed and/or desired services.

ISSUE 4

In the report mentioned earlier, GAO noted that "it is possible that some patients may be discharged at a time in their illness when they have substantial needs for care." GAO noted further that "to the extent that Medicare patients are discharged from hospitals sooner and with greater needs for care, PPS may increase the effective demand for the post-hospital nursing home and home health services covered by Medicare."

a. Does the Arizona Hospital Association agree with GAO's assessment that "some patients may be discharged at a time in their illness when they have substantial needs for care?

(i) Can you provide the Subcommittee with any estimates of the increase in the need for home-health and skilled nursing facility care in Arizona?

b. In view of the fact that Arizona's AHCCCS program does not pay for skilled nursing home care, how will these increased needs be provided for?

RESPONSE 4

As noted earlier, it appears that PPS is increasing the demand for post hospital care including nursing home, home health, and visiting nurse services as well as programs and services provided by social service agencies, regardless of who provides coverage. As previously indicated, the average length of stay for patients is declining. The need for alternative settings that are less costly for patients to recuperate and convalesce will increase.

A key aspect of the estimated increase in need for home health, skilled nursing facilities, and other services and facilities, is the desire by these health care providers to become Medicare-certified. In reviewing the statistics for Arizona, there are 61 home health agencies of which 48 are Medicare-certified and there are 91 skilled nursing care facilities with 36 being Medicare-certified. In terms of available beds, the discrepancy between total skilled nursing care beds and Medicare-certified beds in tremendous: 8,263 available beds of which 910 are Medicare-certified.

Although Arizona's AHCCCS program does not include skilled nursing home care, it is the responsibility of the State's fifteen counties to provide long term care services including a mandate that patients be screened to the lowest appropriate level of care. Because of this responsibility mandated by state law, Arizona probably has greater flexibility in meeting the need for a full range of long term care services than the State would have under traditional Medicaid.

ISSUE 5

Legislation has been introduced in Congress to increase the quality assurance mechanisms under the DRG system now in place under Medicare. Do you believe Congress should pass legislation strengthening the quality assurance mechanisms under DRGs?

RESPONSE 5

Without reviewing the specifics of any new proposed quality assurance mechanisms, the Association believes that there are ample mechanisms currently in place to monitor and track quality of care under DRGs. For example, the government has established the peer review organizations which were designed to monitor and track the utilization and quality of Medicare services. In addition, hospital quality of care comes under scrutiny by the JCAH accreditation program and/or Medicare certification as well as state licensure qualification. In addition, hospitals have their own peer review and quality assurance programs internally to further supplement the mandatory programs.

If Congress is considering additional quality assurance mechanisms, the Association would be happy to provide input and feedback on the various proposals. However, it would be our initial position that additional quality assurance mechanisms are not needed unless such mechanisms improve upon and replace existing mechanisms.

In summary, the Association believes there are several significant issues that have been brought out through our research in response to your specific questions which we would like to note for the record and the Committee's consideration. The points are as follows.

In review and evaluation of the impact of PPS on the elderly in Arizona, there needs to be a focus on the health care system in a broad sense and not just the role and activities of hospitals specifically. Each participant in the delivery of health care services should be considered in determining the overall impact of PPS.

2. Although PPS has a significant impact on the health care system and delivery of health care services relative to hospitals, the effects of PPS are just one factor contibuting to the changes occurring in the health care environment. In Arizona, the health care providers have experienced the growth and popularity of outpatient surgical centers and outpatient treatment centers as alternatives to inpatient care. In fact, Arizona was a picneer in the development of this alternative setting. In addition, the Arizona experiment, AHCCCS, and the elimination of certificate of need

statutes have also contributed to the changing environment for the delivery of health care services.

3. If review and assessment reveals that the PPS/DRG system is working, the Association believes that further tightening of the financial reimbursement will eventually lead to a reduction in medical care. Further, if the system is determined to be working, additional change in the new incentives currently employed to again cause and create changes in provider behavior in reaction to a new set of ground rules may be counterproductive.

4. In the determination of the effect and impact PPS has had on such areas as "quality of care", consideration has to be given to clearly defining such terms and the elements to measured.

5. The Association believes and supports the belief that there is no need to create and impose additional regulatory programs on hospitals for the purpose of monitoring PPS.

6. The Association believes that greater coordination with other interested and affected parties needs to occur in the future development and implementation of PPS. As we have noted, the health care provider community (physicians, nursing homes, home health agencies, allied health professionals, and non-health care providers such as social service agencies,) are all impacted as a result of PPS. The effect on these parties, as well as hospitals, needs to be coordinated to avoid lapses or gaps in providing the necessary resources and services to treat the population in need of health care.

7. Another participant in the health care delivery system, which is currently exempted from PPS/DRG program, is the free-standing psychiatric hospital. The Association, who's membership includes six such hospitals, would urge that the current exemption for such hospitals be maintained at least another two years to allow for the completion of studies to determine what prospective payment system would be appropriate for free-standing psychiatric hospitals.

Again, on behalf of the 58 member institutions of the Arizona Hospital Association, we appreciate the opportunity to submit and present testimony to the Committee on the PPS. If the Association can be of further assistance please contact us.

Mr. KOLBE. Thank you very much, Tom. Ms. Klaehn, would you proceed?

STATEMENT OF ROBIN A KLAEHN

Ms. KLAEHN. Thank you.

Mr. Chairman and Congressman McCain, my name is Robin Klaehn. I am the regional administrator for Medical Personnel Pool in Arizona, and its home health agency. And I serve on the Communications Committeee of the National Association for Home Care.

I appreciate the opportunity to share with you the impact of the prospective payment system on the demand for quality, home, health services to Medicare patients in Tucson, in Arizona.

We are seeing that more and more patients fall through the cracks in our Medicare system and these patients represent the most vulnerable segment of our population. Under the relentless pressure to cut back expenditures, we are seeing those cracks in the system grow wider and deeper. The same cost containment pressure that led to the adoption of the prospective payment system also fueled the rapid expansion of home health services. This growth was fully consistent with the intent of the Congress that Home Health Services be made widely available.

Today, however, there appears to be growing concern that home health services are not actually serving to substitute for institutional care, but have become simply an add-on to the total program cost. As far as I am aware, there is no data that define this particular problem. Yet, there has been an incessant barrage of new regulations emanating from the Health Care Financing Administration,

that are intended to ratchet down home health expenditures, and severely restrict the access of Medicare patients to home health care.

This is happening at the very time when the growth of the frail, elderly population, their increased longevity and their earlier discharge from hospitals under the prospective payment system are creating a greater demand than ever before for home care, as a humane and cost-effective alternative to institutionalization.

Tightening the reimbursement screws on Medicare providers has dire consequences for the patients. Who are these patients? They are patients who may not have been discharged when they were without the financial incentive of the prospective payment system driving the discharge decision. For instance, an 81-year-old, bed bound who had been admitted to the hospital in renal failure, and she was subsequently discharged, she was seen by a home health nurse, who found her comatose with a temperature of 106. The nurse immediately accompanied her to the hospital where she was readmitted with a temperature of already 109.

We had an 84-year-old man who was hospitalized for chemotherapy with a diagnosis of cancer of the colon with metastases to the bone and an unresolved urinary tract infection, and a fracture of his hip. He was discharged from the hospital following chemotherapy, already extremely sick and weak from vomiting. While his family support was good, they had not had any training. No referral for home health care had been made. Three days after discharge, this distressed family was referred to us by a friend. He was seen by a home health nurse and found to have a temperature of 101. He was dehydrated, extremely weak and had edema, lung congestion, and urinary retention. He was readmitted to the hospital. Home health services started immediately would have included at least skilled nursing and physical therapy. Had additional intensive services been provided up front, the continuity of care could have prevented complications, and possibly readmission to the hospital.

In general, our communications with referring discharge planners are excellent. Although they are under great pressure, they are meeting the needs of most patients and families. However, there always is room for improvement. We had a case referred to us which illustrates how essential good communications are.

An 80-year-old man was discharged late on a Friday afternoon, and delivered to his home by a contract transportation firm. When our nurse arrived on Saturday morning, she found this man in the chair where he had been left the previous afternoon. He had been alone, completely alone, in the dark, all night without food, without water, unable to move. He had urinated and defecated in his chair and must have experienced the kind of humiliation and hopelessness that we would find difficult to imagine.

Fortunately, we see our clients on the weekends, or he would have remained so until Monday. But, clearly, this is a case where failure of communication and coordination on behalf of a seriously ill, older person, dependent on others for his care, could have had dangerous consequences.

Here in Tucson, we have had a home health task force in place for about 6 years. The group of hospital discharge planners, agen-

cies, and DME vendors meets regularly to work together on issues of communication and coordination of services, and to promote the most effective use of home care resources in the community. The Pima County Association of Licensed Home Health Agencies and the Arizona Association for Home Care are the groups which are continuing to work together to improve the home care resources available in our community. But communication will not be enough, and coordination will not be enough, and efficiency will not be enough, if the necessary home health resources cannot be made available to patients who need them.

By shifting patients out of hospitals earlier, the prospective payment system shifts costs out of the hospital, but also increases the intensity of input required to care for the significantly more complex home care case. HCFA, apparently, regarding these shifted costs, as unwarranted add ons to program expenditures, seriously impedes the ability of the home health industry to care for these patients discharged sooner and sicker as Congress clearly intended.

I was asked to suggest how we can further maximize the delivery of home health care to older Americans without establishing a new program or providing more money. I believe the simple answer is to call an immediate halt to HCFA's relentless chipping away at the availability and skillful home care to which our elderly and disabled are entitled under the law.

The emerging trends that I see in home health care are these: Patients will continue to be discharged sooner and sicker. The demand for high tech care at home will increase. The demand for more intensive patient education in the home will increase. Family and community support systems for home care patients will be taxed beyond their capabilities of responding. More patients will find themselves victims of the revolving door syndrome, as they are shuttled from one care setting to another. More patients will fall through the cracks, discharged from hospitals and unable to qualify for home health care. Unless Congress acts, we run the risk of trapping thousands of our ill elderly and disabled in a Medicare no-care zone.

I join with the National Association for Home Care in asking Congress to take the following action: Enact legislation to forbid the implementation of new cost limits during the period of any freeze on Medicare provider reimbursement. These bills, I believe, are already in process. Direct HCFA to fully withdraw the proposal to eliminate the presumption of waiver of liability for home health agencies. Enact legislation to statutorily define intermittent care as soon as possible. Pass resolutions to designate the week of December 1 as National Home Care Week to educate the public. These actions are essential to protect the Medicare beneficiary's right and access to home health care.

I thank the members of this committee for traveling here, to Tucson, for this hearing, and for giving me the opportunity to appear here today. And I would be pleased to answer any questions you have for me.

[The prepared statement of Ms. Klaehn follows:]

PREPARED STATEMENT OF ROBIN A. KLAEHN, RN, BS, CNA, REGIONAL ADMINISTRATOR MEDICAL PERSONNEL POOL ARIZONA

Mr. Chairman and Members of the Committee: My name is Robin Klaehn. I am the Regional Administrator for Medical Personnel Pool in Arizona, and I serve on the Communications Committee of the National Association for Home Care (NAHC). Medical Personnel Pool is an International Health Care service that provided nearly 35 million hours of care in the home to Medicare and private patients in 1984. Medical Personnel Pool has offered home care services to patients in Arizona since 1971. After the Visiting Nurse Service of Tucson was forced by continuing reimbursement problems to close its doors in 1978, leaving the city with only one agency, the county agency, to care for all Medicare home health patients, Medical Personnel Pool obtained a Certificate of Need and became the first proprietary home care agency in Tucson.

As you are well aware, there have been significant and fundamental changes in the health care delivery system in the years since we opened our office here, not least among them the Medical Hospital Prospective Payment System (PPS) adopted in 1983. I particularly appreciate the opportunity to share with you through this testimony some examples of the impact of the Prospective Payment System on the demand for quality home health services to Medicare patients in Tucson and in Arizona, services they need, services to which they are entitled. We are seeing, every day, that more and more patients fall through the cracks in our Medicare system and these patients represent the most vulnerable and dependent segment of our population. Under the relentless pressure to cut back expenditures in every area of health care, we are seeing those "cracks in the system" grow wider and deeper.

The same cost-containment pressure that led to the adoption of the Prospective Payment System also fueled the rapid expansion of home health services in the 1970's and early 1980's. It was anticipated that increased use of home health services would result in cost saving through decreased nursing home and hospital admissions and reduced lengths of stay. In the 1980's, Congress acted to increase access to home care by eliminating co-insurance and prior hospitalization requirements, eliminating the 100 visits limit, and allowing proprietary agencies to service Medicare patients. This period of growth was fully consistent with the intent of the Congress that home health services be made widely available and barriers to the home health alternative be eliminated. It is noteworthy, as reported in . . . home health line in March, 1985, the number of Medicare Certified home health agencies increased 65 percent from 1972 to 1981. In Arizona there were only 14 home health agencies in 1980. In March, 1985, there were 52. According to the Arizona Department of Health, Office of Health Care Licensure, as of this date there are 86 home health agencies in Arizona.

Today, however, there appears to be growing concern that home health services are not actually serving to substitute for institutional care, but have become simply an add-on to total program costs. As far as I am aware, there are currently no reliable data that define this problem; that is, there are no studies yet available to show what proportion of home care is a substitute for hospital days or nursing home days, and what proportion is the "add-on," the medically necessary care that the elderly and disabled would simply have been forced to do without if home health services were not available. Yet there has been an incessant barrage of new regulations, policies and administration procedures emanating from the Health Care Financing Administration (HCFA) that are intended to "ratchet down" home health expenditures and severely restrict the access of Medicare patients to home health care. This is happening at the very time when the growth of the frail elderly population, their increased longevity, (often with multiple, chronic medical problems) and their earlier discharge from hospitals under the Prospective Payment System are creating greater demand than ever for home care as a humane and cost effective alternative to institutionalization for elderly and disabled Americans. I cannot agree strongly enough with the National Association for Home Care's recent testimony to the Senate Budget Committee that ". . . it makes no sense to pursue policies (such as the Prospective Payment System) which encouraged deinstitutionalization while hindering the ability of home health agencies to deliver the medically necessary service patients require upon discharge."

Home health agencies (HHA's) have experienced unprecedented numbers of claims denials during the past eighteen months, for technical and medical reasons. The latest and heaviest blow dealt home health agencies by HCFA was the new costs limits imposed July 5th to apply to individual services. Tightening the reimbursement screws on Medicare providers has dire consequences for patients. A patient released too soon from the hospital may not find a skilled nursing facility bed

available. When no bed is available or the skilled nursing facility won't accept the patient, the hospital may not re-admit within seven days since it will not get another DRG payment. A home health agency assuming responsibility for the patient's care is at risk for denial of services on medical necessity grounds. Why? Because the patient requires intense visiting by nurses and aides, to prevent further deterioration of health. The intermediary decides that the patient should be in a skilled nursing facility and denies the visits. The home health agency must abandon the case and the patient is left on his or her own. Perhaps this patient will be readmitted to the hospital, or deteriorate enough for admission to a skilled nursing facility, if a bed is available, or recover unassisted, slowly, or perhaps the patient will not recover.

Who are these patients? I was asked to provide the committee with examples of patients who have been discharged from hospitals to home care in what I would call highly unstable conditions. In my opinion these patients may not have been discharged when they were, without the financial incentive of the Prospective Payment System driving the discharge decision; and surely would not have been discharged without careful planning and coordination to assure continuity of care following discharge:

An 81 year old bed-bound woman had been admitted to the hospital in renal failure. She was subsequently discharged on a Wednesday with a referral to the home health agency. She was seen early Thursday by the home health nurse, who found her comatose with a fever over 106°. The home health nurse immediately accompanied her to the hospital where she was readmitted with a temperature of 109°. She was later discharged to a skilled nursing facility.

An 84 year old man was hospitalized for chemotherapy with a diagnosis of cancer of the colon with metastasis to the bone, an unresolved urinary tract infection and a fracture of his hip. He was discharged from the hospital following the chemotheraphy, already extremely sick and weak from vomiting. While his family support was good, they had not had any training in nursing, positioning, transferring or assistance with mobility. No referral for home health had been made. Three days after discharge, this distressed family was referred to Medical Personnel Pool by a friend. He was seen by a home health nurse and found to have a temperature of 101°; he was dehydrated, extremely weak, and had edema, lung congestion and urinary retention with its attendant pain. He was readmitted to the hospital. Home health services started immediately would have included at least intermittent skilled nursing and physical therapy. Had additional intensive services (including a home health aide and medical social worker, combined with the appropriate discharge planning) been provided, the continuity of care would have prevented complications and readmission to the hospital.

A 72 year old man, living in southern rural Arizona, was diagnosed with a cerebral vascular accident (stroke), and was discharged and referred to home health. He was to be seen for observation of the side effects from the drug coumadin, and to draw blood for coumadin levels because there was no lab in the rural area. During the second nursing visit, the physical assessment revealed the signs and symptoms of digitalis toxicity. The patient was immediately referred to his physician and rehospitalized. While this case does not directly reflect the pressure toward early discharge under the Prospective Payment System, it is typical of home health cases in many rural areas of Arizona where close coordination and communication among hospitals, physicians, and home health agencies are critical to the continuity of care for the post-hospital patient.

There are many more examples in our case files to support the information given to the Genral Accounting Office by home health agencies around the country, that indeed patients are being discharged "sooner and sicker" under the Prospective Payment System. Hospital discharge planners, too, are aware of the problem, particularly the greater need for patient education. As reported in . . . home health line last March, the home health director for a 1,000-bed urban hospital in Connecticut told a Home Care Conference that "the 'aucity' (or sickness) level of patients discharged for referral to home health agencies has increased and the home care patient requires more services, more supplies and more DME (durable medical equipment)" as a result of prospective payment. "I wake up worrying about some of the discharges," she said. She urged home health agencies "to help take up the slack in patient education that has resulted from the Prospective Payment System (PPS)."

In general we find that our communications with referring discharge planners are excellent; although they are performing their coordination functions under great pressure, they are meeting the needs of patients and families and doing an excellent job of it. However, there is always room for improvement. We had a case referred to

us not long ago which could have been a tragedy, and illustrates how essential good communications are. An 84 year old man was discharged late on Friday afternoon and delivered to his home by a contract transportation firm. It is our agency policy to see a referred patient within 24 hours (regardless of the day). When our nurse arrived Saturday morning, she found this man in the chair where he had been left the previous afternoon. He had been alone, completely alone, in the dark all night, without food, without water, unable to move, he had urinated and defecated in the chair, and must have experienced the kind of humiliation and hopelessness that we would find difficult to imagine. Fortunately for this man, we see our clients on the week-end, or he would have remained so until Monday. But clearly, this is the case where failure of communication and coordination on behalf of a seriously ill older person, dependent on others for his care, could have had dangerous consequences.

Here in Tuscon we have had a Home Health Task Force in place for about six years. The group (consisting of hospital discharge planners, home health agencies and DME vendors), meets regularly to work together on issues of communication and coordination of services for home care patients, and to promote the most effective use of home care resources in the community. I am very proud to have been a part of that Task Force and its work since its formation. The Pima County Association of Licensed Home Health Agencies, and the Arizona Association for Home Care are other groups continuing to work together to improve the home care resources available to our community, and to promote the efficient coordination and management of those services.

But communication will not be enough, and coordination will not be enough, and efficiency will not be enough if the necessary home health resources cannot be made available to patients who need them. The Prospective Payment System was enacted by Congress in the expectation that increased demand for post-hospital home care could be met, and would be met by the existing network of home care providers of all types that had grown so rapidly in recent years. By shifting patients out of hospitals earlier, the Prospective Payment System shifts costs out of the hospital, but also increases the intensity of input required to care for the significantly more complex home care case. By input, I mean the frequency and duration of visits, the technologies and equipment and supplies. These resources represent costs that are shifting out of hospitals and into home care. That is as it should be. But the Health Care Financing Administration, apparently regarding these shifting costs as a unwarranted add-on to program expenditures, seriously impedes the ability of the home health industry to care for those patients discharged "sooner and sicker," as Congress clearly intended.

I was asked to suggest how we can further maximize the delivery of home health care to older Americans without establishing a new program or providing more money. I believe the simple answer is to call an immediate halt to the Health Care Financing Administration's rententless chipping away at the availability and scope of home care to which our elderly and disabled are entitled under the law.

Over the last two years we have witnessed a series of actions on the part of the Health Care Financing Administration which will reduce the ability of home health agencies to deliver services to elderly and disabled Americans. Acting with little or no consultation with effective providers and consumers:

HCFA has proposed regulations which would have the effect of eliminating waiver of liability of protection of home health agencies. Under the waiver policy currently in effect, home health agencies with a quarterly denial rate of 2.5 or less are paid for denied services if it is determined that the home health agency did not know or could not have reasonably known that the services were not reasonable and necessary, or constituted custodial care. HCFA now proposes to hold home health agencies to a 100% standard of accuracy, despite a 32.4% rate of reversal on appeals of home health agency denials. Home health agencies often receive inconsistent and unclear directives from intermediaries.

The Health Care Financing Administration (HCFA) has implemented new home health cost limits which abandon the current method of calculating the cost limits for reimbursement to home health agencies on behalf of beneficiaries who require and are entitled to home health care services. For the past five years, home health agencies have operated under a system which sets the reimbursement limit on each visit at the 75th percentile of overall national agency costs. The fact that the rates are currently calculated in the aggregate allows an agency the flexibility to provide certain kinds of care which exceed the cost limits. High cost services (e.g., physical therapy) and the cost of providing free care to indigent patients are offset by being under the limit in other services. The ability to aggregate allows an agency to stay beneath the cost limit overall, while providing the full integrated range of care. The new method instead sets the cap at 120% of the mean of visit cost for each individ-

ual discipline and eliminates use of "aggregation." As a member of the National Association for Home Care and as an individual home health agency Administrator, I Strongly support Senate Bill 1450 and House Bill 3202 which would nullify this new methodology. Without Congressional intervention, we fear the result of this proposal will be, not only to decrease the quantity of services available, but also will jeopardize the quality of care rendered to elderly and disabled beneficiaries.

The Health Care Financing Administration sought imposition of a $4.80 co-payment on all home health visits after the 20th. The proposal would unfairly increase the burden on Medicare beneficiaries. Medicare beneficiaries are already required to make significant out-of-pocket expenditures to finance their own health care. Far from saving millions of dollars, co-insurance would result in increased cost to Medicare. Home health agencies and/or the government would be put in the position of collecting insurance from the elderly. The administrative costs in doing so would be enormous, and would necessarily be passed along to Medicare. Fortunately, both the House and Senate in their respective Budget Resolutions rejected the proposal. We remain hopeful that the Senate Finance Committee will also reject this proposal.

The Health Care Financing Administration has attempted to redefine "homebound" and "intermittent" in order to further restrict the availability of home health services. Existing Medicare home health benefits continue to be unjustifiably limited, contrary to Congressional intent, by restrictive and inconsistent interpretations of the term "intermittent care" as defined in the Medicare Statute which determines the nature and frequency of home care available to nearly two million elderly, infirm and disabled beneficiaries. The implications of these varying and inconsistent interpretations of "intermittent care" are that there are thousands of cases where patients who have been authorized by physicians as medically needing home care have been denied home care outright, or have had home care severely limited. The implementation of the hospital Prospective Payment Plan has exacerbated the already acute "intermittent care" problem. Senator John Heinz and Congressman Henry Waxman introduced legislation last year which would have defined "intermittent care" statutorily. This legislation, unsuccessful in the last Congress, has been reintroduced in this Congress (S. 778/H.R. 2371). Without the aid of such legislation, providers are subject to widely inconsistent determinations of fiscal intermediaries in making key coverage decisions and many patients in critical need of services at home will find their access to medically necessary home care coverage denied.

Val Halamandaris, President of the National Association for Home Care, in his July 19, 1985 testimony before the House Select Committee on Aging, enumerated some of the drastic effects that could result from these kinds of restrictive regulations:

The level of home health services which Congress has mandated by statute for Medicare beneficiaries will be significantly reduced at a time when the demand for such services is sharply increasing. The reason for the increase is the enactment of a prospective payment (DRG) system for hospitals which creates incentives to move patients from hospitals into home care.

Agencies will drop out of Medicare. Hundreds of agencies will go bankrupt.

Agencies will no longer offer important but costly services, such as physical therapy, for which they will not be adequately reimbursed.

New agencies and small agencies will be hardest hit, regardless of how efficient they are.

Agencies in rural areas will be devastated. Such agencies have significantly higher costs as they try to deliver services. Therapists and social workers are often scarce and therefore more costly in rural areas. This increases the per visit length and cost. The policy of undermining rural home health agencies puts the Federal Government in the incongruous position of spending millions of dollars in grants and loans to help such agencies with one government program (the Public Health Service) and making it virtually impossible for them to serve clients through another program.

Agencies which provide so called "high-tech" care such as the care of ventilator-dependent persons, IV chemotherapy, or IV nutritional therapy will find it increasingly harder to do so. These services have relatively high costs and will be discouraged under the new reimbursement system. Ironically, these are among the very services which make it possible to move patients from hospitals into less intensive settings.

Agencies will be forced to be selective about which Medicare patients they take. Agencies may be reluctant to accept so called "heavy care" patients (such as stroke victims), whose cost per case is relatively high, and the elderly indigent.

The level of paperwork required by the new system will increase dramatically, leading to a higher Medicare cost; ironically, such costs will have no relation to the provision of Medicare care.

You have asked me to comment on the impact of the DRG system on the delivery of health care, including home health care, to senior citizens in Arizona and the effect on the health care delivery system in general in our state, which has a higher proportion of senior citizens than the national average and which is the only state in the nation without a Medicaid program. These are the emerging trends I see in home health care:

1. Patients will continue to be discharged "sooner and sicker."
2. The demand for high-tech health care at home will continue to increase.
3. The demand for more intensive patient education and instruction in the home will continue to increase.
4. Informal (family and community) support systems for home care patients will be taxed beyond their capabilities of responding.
5. More patients will find themselves victims of the "revolving door syndrome," as they are shuttled from one care setting to another and back to the hospital.
6. More patients will "fall through the cracks," discharged from hospitals and unable to qualify for home health care.

Essentially, unless Congress acts, we run the risk of trapping thousands of our ill elderly and disabled in a Medicare "No Care Zone."

In light of the problems I have discussed here, I join with the National Association for Home Care in asking the Congress to take the following action:

Congress should enact legislation (S. 1450/H.R. 3202) to forbid the implementation of the new cost limits during the period of any freeze on Medicare provider reimbursement, or until October 1, 1986.

Congress should direct HCFA to fully withdraw the proposal to eliminate the presumption of waiver of liability for home health agencies.

Congress should enact legislation to statutorily define "intermittent care" (S. 778 and H.R. 2371), as soon as possible.

Congress should pass resolutions (S.J.R. 139 and H.J.R. 319) to designate the week of December 1 as "National Home Care Week." Home Care Weeks have been proclaimed each year since 1982. Awareness of home health care has increased because of these resolutions, which are no cost to the government.

These actions are essential to protect the Medicare beneficiary's right and access to home health care. I thank the members of this Committee for traveling to Tucson for this hearing, and for giving me the opportunity to appear here today. I would be pleased to answer any questions you might have.

Mr. KOLBE. Thank you, Ms. Klaehn. And I want to thank all three of our witnesses for, I think, some very in depth and complete testimony.

Congressman McCain.

Mr. MCCAIN. Thank you, Mr. Chairman.

And I would like to thank the members of the panel for their testimony.

Dr. Henderson, you mentioned in your written testimony that DRG's might be successful if physicians become "more comfortable with this system." What is it about this system that makes them uncomfortable, and what changes need to be made?

Dr. HENDERSON. Well, I think that, as I alluded to, the system puts us in a position of being sometimes at odds with the hospital, and I think that is an overall philosophical problem that I do not know that the system could be changed to address. But that is what I was referring to.

I think, as of right now, we are not experiencing terrific problems with the system, but, again, if the system is ratcheted down so that the days allowed for the various DRG groups is less and less, then I think we could get more uncomfortable with it. As it is now, we are able to work within it, and I think that, as a general group, the physicians have tried to make the system work, and I think

that we are, in fact. We need a little more time to see how it is going to work, because we really have not had enough experience with it.

Mr. McCAIN. In your opinion, Dr. Henderson, and Mr. Plantz, are the rural hospitals in the State of Arizona, in jeopardy? And, if so, what will be the impact of rural hospitals closures in our State?

Mr. Plantz, if you would like to begin?

Mr. PLANTZ. On behalf of the Association of Hospitals, again, Congressman, I think that is a very good question. Dr. Henderson alluded to it in his remarks. I think it is factual. I think our rural community hospitals in the State of Arizona, as well as around the country, are suffering. They are suffering not only from DRG impact—I think that is as yet but one facet of that—the ratcheting down, the tightening of moneys, et cetera.

They are suffering, also, from a lack of census or occupancy. Many of those facilities can no longer afford to provide the kind of quality care that they wish to provide to their patients. Their patients, therefore, are bypassing them. Particularly seen here in southeastern Arizona, where the patients often times drive the 50 or 100 miles up the highway to Tucson, to the specialized hospital, you can understand where the patients come from in that respect. We can understand therefore, what effect that might have businesswise, censuswise, on the hospitals in the rural communities. I think DRG's play an effect; they affect also, from the reimbursement standpoint, all hospitals, not just rural hospitals. Everybody is struggling, trying to make the system work.

The small rural community hospitals that we are talking about of usually 50 beds, or less, do not have the flexibility. They do not have the critical mass with which to react. They do not have the staffing, the manpower, and so forth, with which to react within that system. And, therefore, in some instances already in our State their doors have closed. So we are concerned, as a hospital delivery system, about that question.

Mr. McCAIN. If, indeed, Mr. Plantz' statement is true, and yours, too, Dr. Henderson, I think we are facing a severe problem. Perhaps we ought to address that as soon as possible.

Finally, for all three of the witnesses, I would just like to ask if they understood or appreciated Dr. Koff's statement concerning the need for a continuum of care? I would like your comments on his statement.

Ms. Klaehn, if you would begin?

Ms. KLAEHN. Thank you. Home health care is part of the continuum of care and has been in Pima County since the Model Cities Program under the area agency, I believe in 1973–74, and has grown each year, as the needs have grown.

I would also like to comment on the rural home health agencies, if I may, who are really in dire straits with the new regulations. When you deliver home health care in a rural area, you are dealing with very long distances and maybe a very ill patient 60 miles from nowhere, which drives the cost up tremendously, and makes it terribly difficult to provide the specialty services like physical therapy that will make that patient independent again.

Mr. McCAIN. Then you are in agreement with Dr. Koff that the need for a continuum of care is probably the greatest single problem we face in health care today?

Ms. KLAEHN. Absolutely.

Mr. McCAIN. Thank you.

Mr. Plantz.

Mr. PLANTZ. As Dr. Koff knows, I always agree with Ted.

I think his points were cogent. I would support his motion. I think just to key on one of the points that Dr. Henderson alluded to in his comments, when he referred to a step-down unit that our hospitals need to develop those kinds of services where a patient does not need the intense acute care element, and may not be quite ready for the nursing home, or discharged to home and home health care services, but there is that shade of gray in between.

I know, in our own organization, now—and I am not speaking on behalf of all hospitals in the State, but in our own system, we are currently developing that step-down unit, that sort of is the intermediate step between in-patient acute care, and discharge from the hospital. So, I think that is all part of the continuum that Dr. Koff is speaking about. And I think it really merits looking at.

Mr. McCAIN. Dr. Henderson?

Dr. HENDERSON. I agree with his concept, but I just wanted to state that the physicians have been the patient's advocate all along. And will continue to be, and I am not sure that I understand the concept of manager; his concept of someone else, other than the physician, being involved at the very outset, to plan the discharge and plan the continuum. But I would be happy to be educated about that, further, but I just wanted to—I think the physician has always been the patient's advocate, and will continue to be so.

Mr. McCAIN. Thank you. I think we could get into a dialog about that, but I certainly appreciate your sentiments, Dr. Henderson. Thank you very much.

Mr. KOLBE. Dr. Henderson, in your testimony you refer to the fact that hospitals really were pressuring physicians to make the discharge of patients before the introduction of DRG's. Would you agree, then, that the impact of DRG's on physicians has been relatively small and really has not had that tremendous an impact?

Dr. HENDERSON. I think that has been our experience here in Tucson, but, again, I think the system is early and I think that the potential for changing the practice of medicine in a big way is there. But I do not think it has impacted that much on us, so far.

Mr. KOLBE. In his spoken testimony, Dr. Duncan spoke about the winners and losers, the profiling of physician winners and losers relative to the DRG reimbursement. Let me just read you the sentence from his written testimony.

He said,

> There is also evidence that some institutions may be exerting pressure, albeit subtle, on physicians to discharge patients earlier through the profiling of physician winners and losers, relative to DRG reimbursement, and presenting these in open environment, staff department meetings, with the implicit threat of privileging.

Is there any experience that you can tell us about? Has that happened, or not?

Dr. HENDERSON. We have had several of those lists that have been put on in staff meetings, but so far, they have been private. They have not been posted to the best of my knowledge.

Mr. KOLBE. Well, is even the private circulation of such lists—is that——

Dr. HENDERSON. Well, you can see the potential there, and, that again, I think, is part of the ongoing changes that could be wrought and you could see that if you had somebody who was costing the hospital a lot of money, that there would be a way of dealing with it, by posting that in some way, or letting the word get out, and supporting it with data.

Mr. KOLBE. I think, in fairness, we better let Tom respond also to this question.

Mr. PLANTZ. I was just reaching for the mike. I am not going to disagree with Dr. Henderson. After all, he is the past chief of staff of one of our hospitals. His concern, I think, is well stated, or his point is well taken.

I would say this. I do not like the word "pressure" personally, and there is no evidence, at least in our hospitals, and I do not know of any evidence throughout the State of Arizona, where hospitals are really "pressuring" their physicians to get the patients discharged. Yes; there are contacts with the physician by hospital personnel, little reminders along the way, that say, "You know, doc, the DRG is coming up on this thing. You have had 4 or 5 days here and unless you can document further necessity of illness, or care required for that, we are going to have a problem." Now, if that is going to be construed as pressure, that is pressure. But I think the important point to mention here is the hospital has a reasonsibility. It has a responsibility for its bottomline, certainly it does—and for its financials, but it also must work and it does work, I believe, with the physician.

The physician, contrary to some of the other testimony I've heard earlier today, discharges the patient. The hospital does not discharge the patient, ever. The physician makes that judgment.

Mr. KOLBE. Let us allow the testimony to be heard here.

What about, though, the possibility of this kind of pressure that is put on the doctors? If the ratcheting you spoke of takes place, is there not a real possibility that hospitals could find themselves involved in that?

Mr. PLANTZ. Absolutely. Without hesitation, I would say that, and I think, as that ratcheting further occurs, the pressure points will build, and I think there is going to be greater encounters then, between physicians and hospitals in that.

Mr. KOLBE. Well, let me ask both Mr. Plantz and Dr. Henderson, we heard from two persons on our first panel about the kinds of personal problems and experiences that they had. And we also heard from Ms. Klaehn about some personal experiences that she has had with patients. What would each of you say is the lesson that we, as a committee or in Congress ought to draw from those kinds of experiences?

Are they simply individual isolated cases? Is the lesson to be something about the need for other kinds of care that should be provided, outside of the hospital setting? Is the lesson that we need

to learn from that, the dangers of ratcheting down the system too far, or all of the above?

Mr. PLANTZ. Congressman, in framing your question, I think you are beginning to already supply some of the solution. Specifically, the testimony from the first two ladies on the first panel this morning, and I, for one —and I believe everyone in the room I am sure—listened very intently. Those are legitimate concerns; let that be stated clearly.

Those are people with hurts and pains that need to be addressed. Now, some may blame the hospitals and some may blame the physicians, for that plight, but in the final analysis, what they are asking for is attention to their infirmities and that is part of where the system, if I may suggest, is a bit insensitive. It treats all hernias and gall bladders, and all heart attacks the same.

Congressman, when you have your heart attack, and when I have mine, they may be entirely different. I hope we are treated as individuals, and I think that is what our two ladies, this morning, were saying, on the first panel. Be sensitive to that point.

I would also say that, if there is but one or two inappropriate discharges early from any hospital in this United States, that that is probably too many, very frankly. And the issue of quality of care—all of us, physicians, hospitals, and government, alike, need to worry about that point. But I think, in framing your question, you've begun, already, to hear what this testimony has brought together this morning. I think therein lies some of the solutions, as you mentioned, Congressman Kolbe.

Mr. KOLBE. Thank you. Dr. Henderson, do you want to comment on that?

Dr. HENDERSON. Just briefly.

I certainly agree with what Mr. Plantz has to say, and I think that these stories just point up the fact that there will be cases that sort of fall through the cracks. And with a relatively young system that it probably will work OK, but it certainly is too bad that there is not good communications sometimes. Some of these things I think could have been avoided with better communication.

Mr. KOLBE. As always, I find myself running out of time, here, with lots of questions that I wanted to ask. But, looking at my watch, and realizing we have one more panel to go, and that we still want to leave some time for public testimony, I am going to close with this panel.

Again, thank all of you for the very excellent testimony which was given.

Thank you.

Mr. KOLBE. On the last panel, Ms. Klaehn and John McCain asked about problems in the rural areas. In this fourth panel, we are going to hear about some of those problems in the counties and cities outside of Tucson, and outside of Pima County.

We have with us, the director of Cochise Aging Services, Stewart Grabel. And, also from the SEAGA, the Southeastern Arizona Government Association, Kathleen Heard.

So, let us proceed directly, and begin with Stewart Grabel, director of the Cochise Aging Services.

PANEL FOUR, CONSISTING OF STEWART GRABEL, DIRECTOR, COCHISE AGING SERVICES; AND KATHLEEN HEARD, DIRECTOR, AREA AGENCY ON AGING, SOUTHEASTERN ARIZONA GOVERNMENTS ORGANIZATION, BISBEE, AZ

STATEMENT OF STEWART GRABEL

Mr. GRABEL. I would like to thank you, Congressmen, for inviting us to testify on behalf of myself, but more primarily, our clients and our staff.

I find it interesting that some of the testimony today has indicated that there is not statistical evidence to show that people have been released earlier from the hospitals under the DRG's, because all of the folks who have testified about providing in-home services have stated to the contrary that their caseload is much higher, as a result of these people being discharged. I think part of the statistical problem may be some definitions.

For example, in my written testimony, I quoted a case involving a lady that did have hernia surgery, and that is the third time that hernia surgery has been used as an example. She is 83 years old. I am sorry—87 years old. I stand corrected, and yes, she was treated for hernia surgery as an outpatient. She was discharged from the hospital the same day she was admitted, with a 3-inch deep scar that had to continually be drained and had to be monitored constantly. And yet, it is not declared as a premature discharge because it comes within the definition of what the DRG is supposed to do.

So that could be why our statistics, as such, do not indicate what is happening, because that is maybe what is supposed to happen under this system.

I think that one of the problems that we face in the rural part of Arizona is a lack of choices and options. And that is, should a physician be displeased with his hospital, or how the hospital is functioning, he does not have much choice of going to another hospital. Most of the communities in Cochise County are served by one hospital, and either you have privileges at that hospital, or you move.

That is not so subtle a pressure, I think, on the physicians. The physicians are, as of a necessity, concerned with the well-being of their hospital because, again, if their hospital goes under, they do not have an option of another one. So, the pressure is not as subtle as we would like to think it would be. I cannot imagine any of us, under the knowledge that the hospital needs a certain amount to function, and I need the hospital in order to function, I cannot imagine any of us, under similar circumstances, necessarily acting any differently on their behalf.

I think that one of the things that Ted Koff spoke about that is most important, and most urgent, is that we take a look at funding the interim care services, the care between the hospitalization and what someone needs in their home. Often, it may not even be medical care. They may not need to have a nurse, but they may need someone to give them a meal, or they may need someone to give them—to clean their house or to clean their carpet or to flush their toilet, or to do any of a hundred other little tasks that once they are released from the hospital, although medically, they are on the road to recovery, they still cannot take care of by themselves. And

these are the things that are going to have to be considered, as someone previously testified, probably on admission to the hospital. Because discharge is too late. If we wait until discharge, and a problem that some of the physicians are faced with planning for this is that the physicians are used to giving an order in the hospital and then the hospital staff carries it out, and then the hospital staff adds that to the bill, as part of the charges for the patient.

When the patient is discharged, that cost—the patient may still write up their prescription, OK, this person needs a home delivered meal, but if my agency is at the limit for the number of meals that we can provide at this current time, where do we get the funding to provide that additional meal?

My agency has recently had a staff meeting in which we discussed this, and we have decided that we are going to have to say, No. Because we do not have the money to provide additional meals.

Our agency was originally funded as a congregate meal program, and then home delivered meals came in. We originally served about 15 percent of our meals to homebound individuals. We are currently at 65 percent of our meals. What that has meant is that we have taken meals from our congregate program, the wellness program, a program that is geared to keeping people healthy, and we have had to shift it into an acute care program, if you will, to give meals to patients who are being released from the hospital on a fairly emergency basis.

The situation that was just testified to about a patient being left in a wheelchair overnight, after discharge from the hospital is not that rare in our experience. We have seen it in several of the communities in Cochise County, where the patient is home, we get the referral, and we go in there and we find out that nothing has happened, or that a neighbor calls one of our meals people, and we go in there and investigate. And we find out that they have been discharged from the hospital, and they do not know why; they do not know what is going on; they do not know where—and someone has to pick it up.

The other instance that really concerns our agency primarily since we do not go for Medicaid or Medicare or any other type of funding, we feel that if the funding is there, there are agencies that are willing to provide the services. We deal with those people who do not meet any of those criteria—who do not fit in those services, and we are funded through State funds and through area agency on aging. And those people are increasing in their needs at a tremendous rate. In my written testimony, I said our demand for our nursing services increased 158 percent in the last year. That indicates that there is a great need out there.

I do not want to—it is late in the afternoon and most of anything else that I would say, has been said before, but I did feel the need to come and say those things and to add, just as a conclusion, that we have begun to participate in a case management program, again through our area agency and the State agency on aging.

It is funded very minimally, and one of my original concerns with case management was that, in order to do the case management, we had to take money away from our home care program. That is, the pot did not grow; it is just that we assigned some of it

from home care to case management, and what we are trying to do with the case management is to find alternative sources of services.

That is perhaps we could arrange for a sister, or a son, or some other folks to come in and help meet some of these needs. But the basic problem has to be dealt with on both ends.

One end is it has to be dealt with at the time of hospitalization. That is, when you go into the hospital, the patient ought to be told what they can expect when they come out. Because it is too late to tell them when they are coming out, because, often, they have just been under surgery; they have just had a whole bunch of trauma and they are simply not capable of making the contacts, at that point in time, to follow through, even if those services were available. So, we think it is very very important that both ends be handled.

A question was asked about the physician's role in this. And I think that the medical profession has a huge scope of responsibility, as it is. And I am not so sure that our physicians are going to want to spend the time becoming social workers and doing this. But there has to be some facility, some part of the system, that does cover it. And I am not sure that the physicians ought to be. But there ought to be discharge plans.

I was speaking at the last break to a couple of people, and I know, in rural hospitals, one of the first positions to go when there is a budget crunch, is the social worker. And then the social worker again gets hired just before certification. I have seen that happen in a couple of hospitals in our area, because you have a social work staff in order to have hospitalization—in order to be certified. It just miraculously seems to happen like that. I do not think that there is enough attention being placed on discharge planning.

I know that people are being discharged sicker. There is no doubt of any of the people who are in the home health care field that that is going on. That the physicians and the hospitals and the administrators question that as a fact strikes me as amazing.

Thank you, again, for allowing me to testify.

[The prepared statement of Mr. Grabel follows:]

PREPARED STATEMENT OF STEWART GRABEL, DIRECTOR, COCHISE AGING SERVICES OF CATHOLIC COMMUNITY SERVICES OF SOUTHERN ARIZONA, INC.

I am Stewart Grabel, Director of Cochise Aging Services, which provides a variety of services to the elderly in Cochise County. In addition to operating eight nutrition sites serving over 600 meals per day, we provide a full range of home care services ranging from housekeeping to skilled nursing. Our advisory council, which is made up of our clients, feel a strong vested concern in the matter of the implementation of DRG's. On behalf of our clients and our staff, I thank you for this opportunity to present this testimony.

In July of 1984, our program provided 25 hours of skilled nursing and 302 hours of Home Health Aid services. In July of 1985, we provided 64.5 hours of skilled nursing and close to 488 hours of Home Health Aid service. Increases of 158 percent and 62 percent respectively. In Mohave County, Anne Robbins reports a 100 percent increase in the number of home delivered meals being served in her program. The most significant reason for the increase in the level of services demanded, is the implementation of the DRG's.

By setting limits upon what Medicare will pay for during hospitalization, DRG's have set an average length of treatment which all too often disregards age, infirmity and community support systems. Many elderly are released in conditions that require levels of care neither funded nor available in the community.

An elderly (over 80 years old) female was discharged from acute care with a post-surgical wound that measured 8" long, 1½" deep and gaped open approximately 3". She needed daily dressing changes and wound assessment, housekeeping, personal care and home-delivered meals. Medicare would probably have covered several visits to teach her how to do her own care, but even with the lessons, she would have been unable physically and emotionally to perform these tasks.

If cost was the only consideration, then the best and most effective way to restrain the rise in costs is "not to spend money." But the provision of health care to those who need it is the issue. Judged by the single criteria of cost, the DRG's will be successful, judged by the second, it must now be considered a failure. For it to succeed by both standards, it will have to take into account the needs of the patient, as well as the society and community who will sustain him. There must be sufficient funding for the in-home services required by early hospital discharge. This must include not only medical care but a means for the person who is recovering, to be bathed, and to have laundry done and a way to get them shopping 'til they are able to do these things on their own. The cost of these services are less than the cost of hospitalization, but more than not doing anything. However, the savings in human life and dignity will be great.

An age 90 plus female who has been a client of DES Adult Protective Services, had been assessed as needing Intermediate Care, when actually she needed Skilled Nursing Care. The reason she was not classified as needing skilled care was because no one knew the client was incontinent. She kept it a secret from all except our workers. They did not know that the fact she was incontinent was unknown to the country and the APS. By the time the error was discovered, there were no local skilled nursing beds available.

A female, 89 years old, was ill but unable to be admitted to the hospital because her situation was not acute enough. She died in the night at home.

Sometimes, though there is no need for continued medical treatment (that is given time the patient will heal and recover) condition of the clients precludes their being able to care for themselves in the community without support.

Two women, aged 70 plus, were discharged after hospitalization for fractured hips. Both lived alone. One was isolated with no phone. Neither was able to do any kind of housework, and neither had a support system.

They were both given home delivered meals and some home care.

Neither of the women mentioned above need additional medical care but neither could feed or care for themselves, nor shop, or clean, nor do any of the things that make for a civilized life. While keeping them in the hospital may not be appropriate, there must be adequate planning and funding for discharge and post hospitalization services. These must not be limited to medical services. A patient who cannot feed themselves cannot recover properly. One who cannot clean himself, suffers an indignity that may cause the patient to lose the will to live.

An elderly male was discharged from acute care early and without time to get a bedside commode. Although he had a wife who could help him, he was unable to get to the bathroom in time. Since had had no bedside commode, he was rendered incontinent.

There must be developed a comprehensive system of care for the ill and elderly in this country. The system must include funding for the range of services necessary to insure the highest degree of care for the most reasonable cost available. Notice I list care before cost. If we do not do that, some people will never care about anything but the cost. The current system neatly shoves people out of the system and ignores them statistically. A discharged patient who dies in his home of malnutrition, dehydration or loneliness is not counted in the hospital records. There is no review of the cause of death and the system is statistically blameless. Yet the client is just as dead.

Our agency, through our newly instituted case management program, recently held a staff workshop on how to turn down clients who are eligible and in need of meals and/or home care services. The current funding level is not sufficient to meet the need for services. If the current trend were to continue, all of our funding would go to acute needs services and none to maintenance or preventive services. That is, we would be forced to disband our successful congregate meals program in order to provide the necessary home delivered meals. This would result in two things: Those who need the congregate program would deteriorate to a point at which home delivered meals would be required for them, and we would not have the congregate program to serve those who recover from their conditions as a means of therapy. We would, in effect, be creating greater acute needs.

Patients, even before they enter the hospital, should be told how long their stay will be, what will they need when they get out, and will they be able to care for

themselves. Prior to discharge community services must be consulted in time to set up a plan to care for the patient, whether that requires setting up family or neighbors or social service agencies if needed. The traditional care givers in the family and neighborhood must be educated as to the needs of the patient, particularly in the case of terminally ill patients. Discharging a patient and telling the family that "there is no further medical treatment available so he is being sent home" and nothing more—leaves everyone, including the physician, frustrated and angry.

In conclusion, the concept of reducing medical cost by limiting hospital stays is having a negative impact on the elderly. It must be balanced with usually less expensive support in order to effectively maintain the patient upon discharge. There must be adequate consideration given to the well being of the patient upon discharge. This includes information for patient and family. Funding for community based support system to a degree commensurate with the need must be allocated. To do otherwise is to condemn our elderly and therefor our entire society to a grim uncertain future, and fear of what ever routine hospitalization can do to them.

All the anecdotes recounted in this testimony are documented in our case files and represent only a portion of our negative experience with DRGs.

Mr. KOLBE. Thank you very much, Mr. Grabel. I would like to go directly to Ms. Heard.

STATEMENT OF KATHLEEN HEARD

Ms. HEARD. I would like to thank you very much.

Can you hear me all right? No; I will speak up a little bit louder.

SEAGO is the Area Agency on Aging that covers Cochise, Graham, Santa Cruz, and Greenlee Counties. We contract with five different agencies—two public and three private nonprofit—to provide in-home services. In-home services include home delivered meals, housekeeping, home health, and visiting nurse services. One of the agencies that we contract with is Cochise Aging Services, and you just heard their testimony. The other four agencies that we have contracted with have not really been able to quantify the impact of DRG's.

In other words, they are not quite ready to say that DRG is the reason for the change in the demand for their services, but they have had to shift funding out of housekeeping into home health and into visiting nurse services, because there has been an increased demand for more skilled help. They have also found that they have had more interaction with home health agencies.

One of the reasons that they have had more interaction with home health agencies is that 3 years ago we had one public home health agency. As of this week, I believe, there are nine licensed home health agencies in our four-county area. Some of those were organized by health care providers. There is one that is organized by a physicians' group, and two of them are affiliated with hospitals. And one could argue about the motivation for health care providers to establish home health agencies. Could it be patient care, protection from liability for insufficient care, an attempt to cost shift for Medicare dollars that they have lost in the hospital, or is it strictly that there is demand and there is a profit to be made in this area? But, nonetheless, the fact that there is a demand proves that there are more people being discharged quicker and sicker.

Senior citizens living outside of incorporated communities quite frequently do not have any access to even these brandnew home health agencies. They do not know how to go about accessing them. They may have gone to hospitals in Tucson and been discharged by a discharge planner who had no conception of what it is like to live

in a community like Bowie or Elfrida—no idea that you just cannot pick up the phone and make arrangements for services.

One of the members of our advisory council is a retired nurse who has not kept her license up, because when she retired 15 years ago, the last thing she wanted to do was practice nursing. She has been forced in her home community to care for people who have been discharged from the hospital. Unfortunately, she is now caring for her mother, and was not able to come and testify today.

The other thing that we are seeing from home health agencies is what Stu Grabel mentioned earlier: People use the licensed home health agencies for services that those agencies can provide, but those home health agencies realize that their clients need those delivered meals, those housekeeping services that are not reimbursable, and then what happens when Medicare reimbursement is exhausted after a given number of visits? Those people also come to our public and nonprofit agencies.

As for the elderly, they are completely confused by DRG's. Most of them do not worry much about DRG's until they have to go to a hospital. Most of them believe that Medicare will not allow the hospital to keep them longer than some magical number of days.

Rural hospitals complain that DRG's are putting them in financial risk. Prospective payment systems have been adopted by AHCCCS—Blue Cross and Blue Shield and some other insurance providers. The rural hospitals say they do not have the volume of diagnoses, nor the variety of diagnoses for the average to work for them.

One nursing home raised an issue with us about a week ago. They had a patient who was discharged from a hospital that did not have a physical therapist on hand. So, therefore, neither the treatment plan nor the discharge plan included any mention of physical therapy. So, now the nursing home is trying to make sure that Medicare will reimburse them for the recuperative care that they are planning to give, which includes the physical therapist.

Discharge planning is another thing. We have a real increase in the demand for discharge planning, and it is very evident that it varies. Some hospitals start with discharge planning as soon as the patient is admitted. Some hospitals start with discharge planning as the patient is leaving the door. Some hospitals have somebody who is the discharge planner. Some hospitals have somebody who has "umpteen" other duties and other duties as assigned includes discharge planning. Discharge planners find it really frustrating to discharge somebody into a community they do not know about. They can go to directories; they can call information and referral in Tucson and be told that there is an agency X in such and such a community. But they do not have that day-to-day contact that you do in Pima County, where you have a close knit network of services.

Obviously, there is a greater need for publicly funded agencies, proprietary home health agencies, hospitals, physicians, and nursing homes to coordinate their services, and we would support an independent case-managed system, independent from patient care and independent from service provision.

In summary, what we have seen the DRG's do: Patients are being discharged in poor states of health; the emergence of home

health agencies cannot provide all of the services that these patients need; the demand for community-based services cannot be met, because of inadequate funding; patients discharged into rural communities may not have any services available to them to help them recuperate; the demand for discharge planning is not consistent with the priority given to this function by hospitals; and elderly Medicare beneficiaries are upset and confused.

Thank you.

[The prepared statement of Ms. Heard follows:]

PREPARED STATEMENT OF KATHLEEN HEARD, SOUTHEASTERN ARIZONA GOVERNMENTS ORGANIZATION

As the Area Agency on Aging serving the non-metropolitan counties of Cochise, Graham, Greenlee and Santa Cruz, the Southeastern Arizona Governments Organization contracts with three non-profit and two public agencies for the provision of in-home services. During the contract year that ended June 30, 1985 these five agencies provided 32,023 hours of housekeeping to 602 clients, 11,359 hours of home health care to 404 clients, 2,155 hours of visiting nurse services to 326 clients and 121,504 home delivered meals to 908 clients. These service levels are 13 to 25 percent higher than the prior year's levels. The agency that serves the largest county, Cochise provided over 50 percent of the aforementioned services and has submitted testimony as to the impact of the DRG system on these services. The other four agencies have not quantified the impact of DRGs on the demand for their services, but have shifted resources from housekeeping in response to an increased demand for more skilled home health and nursing services.

The increased demand for home health and nursing services is also evidenced by the emergence in the last two years of home health agencies licensed for Medicare reimbursement. One urban based agency expanded services into this region and three new propriety agencies have been licensed, one of which is affiliated with a physicians' association. Five hospitals have initiated the development of home health agencies. The result is that there are now 9 home health agencies in the four county region, licensed by the Arizona Department of Health Services, when only one public agency was licensed three years ago.

Whether the motivation for health care providers to establish home health agencies is concern for patient care, protection from liability for insufficient care, cost shifting to replace lost Medicare revenues or profitability is debatable. However, the conclusion that the reason for the demand for home health services is because patients are being discharged "quicker and sicker" is supported by public, non-profit and propriety home health providers.

The emergence in this region of home health agencies does not assure that these sicker patients discharged by hospitals will get the services they need. Senior citizens living outside the incorporated communities may not have access to any in-home services. A retired nurse in Bowie has been kept busy caring for neighbors discharged by urban hospital personnel who have no conception of the patients' home community. Home health agencies generally provide only those services that are reimbursable by Medicare, Veterans Administration or insurance and refer clients to the Area Agency funded providers for other service needs such as home delivered meals or for ongoing home health and nursing services once reimbursement has been exhausted, thus increasing the demand for services already in short supply.

The elderly also report that they are being discharged earlier and in poorer health than prior to the DRGs. The explanation that many have been given is that Medicare will only allow hospitals to keep them for a specific number of days. Most do not understand DRGs.

Some of our rural hospitals claim that DRGs put them in financial risk because they do not treat the volume nor the variety of diagnosis to be able to break even under a prospective payment system and that the situation is exacerbated by AHCCCS having adopted a similar payment system.

One nursing home reported that a patient might not be eligible for Medicare reimbursed convalescent care because physical therapy did not begin in the hospital and was not specified in the discharge plan.

Within hospitals discharge planners are in the process of defining and legitimizing their roles with varying degrees of success. In some hospitals the discharge planner actively participates in utilization review committees; while in other hospitals

discharge planning is assigned as an additional task in an employee's job description. Understandably therefore, backgrounds and abilities of discharge planners differ significantly.

In some hospitals discharge planning begins with a patient assessment completed upon admission; while in others so called planning begins as the patient is being discharged. In many instances the discharge planner it not familiar with the patients' home community and cannot comprehend the non-existence of services that may be commonplace in an urban area. However, discharge planners who do know how to access services are often frustrated because with client loads at capacity, service providers are having to deny services.

Obviously there is a greater need for publicly funded agencies, proprietary home health agencies, hospitals, physicians and nursing homes to coordinate services through a formalized system. We therefore support the establishment of client assessment and case management systems that are independent from service provision and patient care, and that are available to the elderly regardless of ability to pay. Based on the assessment, a case manager could serve as the broker enabling the individual to access the most appropriate and cost effective mixture of health related and community-based services.

In conclusion DRGs have resulted in:

1. Patients being discharged in poorer states of health.
2. The emergence of home health agencies that cannot provide all of the supportive services needed by these patients.
3. Increased demand for community based services that cannot meet the need.
4. Patients being discharged into rural communities where services necessary for recuperation are not available.
5. Increased demand for discharge planning that is not consistent with the priority given to this function as hospitals attempt to cut costs.
6. Elderly Medicare beneficiaries are upset and confused by DRGs.

Mr. KOLBE. Thank you very much.

Soon, we will have an opportunity in a few moments for the audience to speak here.

John, would you like to ask some questions?

Mr. MCCAIN. Thank you very much for your testimony.

Ms. Heard, the Older Americans Act designates you as an advocate for the elderly in your area and you obviously are a very active and impressive one. Have your responsibilities in this area increased as a result of the DRG's?

Obviously, from what you said, they have. For instance, have you attempted to educate the elderly on what to expect under this system, and how to plan for posthospital care?

Ms. HEARD. We have talked to some hospitals about doing some training, but it is very dfficult to simply educate people from the perspective of the theory. I think we have got to get the doctors and the hospitals involved in doing that education, because if they have a certain interpretation, and that is the way a rule is interpreted in that hospital, then by our telling people the theory, it may only lead to more problems.

Mr. MCCAIN. Thank you.

Mr. Grabel, you mentioned that you have a newly instituted case management program.

Mr. GRABEL. Yes.

Mr. MCCAIN. Could you elaborate on that, since Dr. Koff and the others have stated that it is one of the areas we need to address. Before you do, I would like to mention—and I am sorry that Dr. Henderson is not here, that I indeed agree that the physician may be the patient's greatest advocate. However, we need oversight and assistance in managing programs such as those you mention. I hope you will elaborate on them. Do you agree with that, and not

as a kind of criticism to the medical profession, but as a very intricate equation, requiring a lot of input and expertise.

Mr. GRABEL. Absolutely. It is a question of another field of being and of being familiar with every, with all of the community-based facilities and services that are available, some of which are related and part of a system, and some of which are unrelated. And I am just not—I do not believe that the physician really has the time to do that. It is not that they would not like to be able to do that. But I am not sure that it would be appropriate for a physician, for example, to spend time with a patient and make long-distance phone calls to locate relatives who might be able to care for the patient. That is something that a case manager might do.

I am going to preface what I say by saying that this is my concept of case management, and it may differ somewhat.

This is the Grabel plan, Mr. McCain. Well, I know that Pima County has had a case management system in effect for some time now, and we borrowed some concepts from them. And I do not want my definition to be construed to preempt Jim Murphy over there from the county as his definition.

What we want to do is to find out what the client needs. Here is a difference in terms from DRG's. It is not a patient. It is a client. Often we use the term "participant" as well, because they are someone who has something to say in what is going to happen to them. The first step in doing that with a physician would be a physical examination. With case management, it would be an assessment.

That is, you would go and sit down with the client or the participant, and discuss with them what they see as their problems, and the discussion and the assessment would be both informal and formal: Informal in that you want to reach the point where the patient is willing or the client is willing to tell you what is going on. I think one of the things I mentioned in my written testimony is a case in which a client did not tell anyone except our worker that she was incontinent, which of course has a great bearing on what type of treatment or what type of facility they would be in. That can only be done when there is a certain rapport that is established.

The second thing is the structured portion of it. Ask certain specific questions. Do you have trouble getting around? If you do, what do you need to help you get around? Then, as a result of this series of questions in this interview, the case manager reviews what is going on, and discusses with the client what they see as their needs for service. Now, with a medical discharge, this would include what the physician sees as their need for servicing including medical services. And we have, as part of our service, nurses on our home care staff that are available to our case management staff.

So, if our case manager notices something that might indicate, and they have gone through training to look for these things that might indicate a physical problem that the patient is not aware of, they might arrange for an interview with the nurse. Now, the problem is that the nurse cannot do anything until, in terms of treatment, until the client is referred to and goes to a physician, and the physician orders the service. And often, one of the greatest tasks of the case manager is to convince the client to go see a

doctor. And you would be surprised in rural Arizona, and I imagine in urban Arizona, as well, how many times it is difficult to get someone to choose between paying their deductible for that, or paying their rent that month. It is a real decision, but the case manager's task is to steer them, if you will, with their consent and cooperation, toward a course of action that will allow them the greatest degree of independence with whatever intervention is necessary to help them maintain that independence.

Now, the greatest degree of independence that an individual may need may be institutionalization. On occasion, that does happen. But we try and find other, what we would like to think of, as cheaper alternatives to that.

The idea of the case manager would be that, upon discharge, in the context of DRG's, would be in the context—OK, we have someone who is ready for discharge from the hospital. The hospital is concerned that the medical treatment is kept up. The case manager would be concerned with arranging for that, and also arranging for those other things.

I think, again, I alluded in my testimony to a case where an individual was discharged without being explained how to use a commode, and so he was incontinent, not because he had to be, but because he could not be trained in doing it. It is just a connection step, if you will. The case manager would take care of making those arrangements. The problem, again, being that it takes time to make those arrangements. It is too late to do it the day the patient is being discharged. Well, if the case manager is brought in early enough, that can happen.

Mr. McCAIN. Thank you.

Mr. Chairman, I may have to leave before the final conclusion of the hearing because I have to go back to Phoenix.

I would like to thank you for chairing the hearing. I would also like to express my appreciation to the people in the audience, who have come here and paid close attention for a long time. They have obviously been very interested and deeply committed to this issue.

I am convinced that if we have enough people in the State interested in this issue, such as we have in the audience today, we will be able to come up with some reasonable solutions to these issues. Thank you.

Mr. KOLBE. I want to thank you, Congressman McCain, for being a part of this hearing today, and we will understand if you have to leave.

I will ask a couple of quick, short questions here, and then we will take some public input here.

Ms. Heard, you discussed the need for community-based services as the DRG system is developed, and you ticked off a whole range of those. Are you taking that into account as you do your planning in SEAGO?

Ms. HEARD. Yes; we are.

Mr. KOLBE. And, of course, I think we probably both agree that it is partly because DRG's, but partly just because of a growing aging population, that there are more demands for home health care services and community-based services. Is that correct?

Ms. HEARD. Yes.

Mr. KOLBE. What kind of planning are you doing to take that into account?

Ms. HEARD. What has happened is, because we have not had any significant increases in budget. Because Arizona has been gaining in population of 60 and over, in higher proportions to what other States have, we have gotten some increases. But what has happened is that we have had to take funding away from services like congregate meals, and other supportive services, in order to address the in-home services and in the reauthorization last year, of the Older Americans Act, we were given more flexibility to be able to transfer funds from the different parts within title 3. And we have had to exercise that. But we have reached the point where we simply do not have the resources, the dollar resources, to continue doing that. Our communities have been phenomenal in the amount of local resources that they have put in, but one of the things we are faced with is the possible disappearance of revenue sharing, and revenue sharing has not always been the funding that provided some of that local cash.

Quite frequently, entities use the local—revenue sharing to buy capital equipment, and then they use general fund money to fund some of the in-home services, and so we have not only the fact that Older American Act fundings have not increased to any significant degree, but we also may be losing revenues through revenue sharing and general fund money.

Mr. KOLBE. I suspect I had better be forthright in telling you that it is not a possible loss of revenue sharing; it is a virtually certain loss of revenue sharing that is going to take place.

What you just said, and certainly what Mr. Grabel has said earlier, touches on the second point I wanted to make. What we are dealing with is a problem of allocation of resources, and I think what I am hearing from you is that perhaps the allocation as DRG's work, if they work, in the cost-containing system, and obviously, Mr. Grabel does not think they are working in terms of providing health care or good quality health care but if they are working that way, we are not reallocating the resources over to the other side where they are needed. Is that a fair assessment of what I am hearing from both of you?

Ms. HEARD. Getting back to what Dr. Koff said, in Arizona, we simply do not have a continuum of care and until we have funding incentives, if you want to use some of the terms some of the medical profession has used today, we are just not going to see some of those other alternatives developed.

Mr. GRABEL. I am going to ask, since I am not a Congressman, I would like to take a purely——

Mr. MCCAIN. Good for you.

Mr. GRABEL [continuing]. A purely political statement that I think what is happening that we are—that a lot of us are making the assumption that we cannot bear these things because there is not enough money available, and I said there should be enough money available. I do not have to start from that position. Perhaps, you, as working on the budget do, my position would be that, yes, these services are necessary and what is happening is that we are creating a greater need by reallocating our resources. That is, we are taking away from support and maintenance programs, and put-

ting them into acute care programs which are more expensive. For example, home delivered meals cost more than congregate meals, for the simple reason that we have to deliver them to individual people, OK. When we—and what happens when those home delivered meal people recover, and they need a setting in which to get their meals there is no longer going to be a congregate meals program, if the trend continues.

The other thing is that our service was funded to provide housekeeping services, home health aide services and skilled nursing services. As we reallocate our funds into skilled nursing services, as the patient gets better, we do not have the other level of service to provide them. So, what it means is that they have to get sicker in order to get the service. We are creating a funnel, if you will, toward the higher end of the spectrum, the more expensive end of the spectrum, and I think that that is something that, in the short term, it may save us money now, but it is going to cost us in the long run. It is going to be more expensive in the long run, and then you are going to have to reinvent the wheel and redevelop these services again.

Mr. KOLBE. Thank you. I will not get into an argument with you about whether or not we are spending enough, too much, or too little on health care. I would point out that since 1950, in the last 34 years, the percentage of gross national product, the measure of all the goods and services that we allocate for everything that is produced in the United States to health care, has more than doubled. That may still be insufficient, and I do not want to get involved in a philosophical discussion of that. But I think what we are beginning to see, and perhaps this is a good point on which to bring this part of the hearing to a close, I think we are beginning to see this as it relates to one aspect of that question, that society is beginning to ask: Are there limits to what portion of our total resources are available to us in society that we allocate to health care because we do live in a world of finite resources?

I want to thank you, Katherine. I want to thank both of our individuals, Mr. Grabel and Ms. Heard, for their superb testimony, and we are going to go directly to public testimony.

Thank you both very much for testifying.

While we are setting up that microphone here, I want to make a couple of points. First of all, several people asked for an address for the Peer Review Organization. We have printed it on a piece of paper out on the table in the foyer, and if you would like it, please copy it down off that piece of paper, as you leave.

Now, we are going to go to public testimonies. Congressman McCain will back me up that each day in the House of Representatives at the beginning of our session, we have what we call 1-minute speeches. You may not believe that politicians could ever confine themselves to 1 minute, but the Speaker up there uses the gavel very vigorously at the end of 60 seconds, and cuts you off in midsentence. I will try not to cut people off in midsentence, but we would like to be able to hear from just as many people as possible. And let me remind you that we will take written testimony and complete testimony will be a part of the record.

So, I will apologize in advance if I use the gavel, but I hope those out there still waiting to try to get a comment made will appreciate the fact that I do use it.

Please, just make the basic point that you want to make, and then, if you have something you want to submit in writing, it will be printed in the record.

I am going to call first on five individuals who contacted us in advance, representing different groups that wanted to be heard for a 1-minute message to us. And we will begin with hearing Michael Smith, representing the Pascua Yaqui Tribe.

Mr. Smith.

STATEMENT OF MICHAEL SMITH, PASCUA YAQUI TRIBE

Mr. SMITH. I would, our chairman, just to stand with me. First, let me hand you the—we have written testimony, and I will not belabor it because I know we are on a time schedule all that we have to say is that, in the State of Arizona, because of the Medicare and other lack of Medicare that the Indians are one more burden to an overburdened resource, and because IHS and BIA work as residual payer of last resort, there is no money through BIA or IHS. And we are using alternate resources. We are just adding one more burden to an overburdened system. And we think—we have made some recommendations we would like you to read in our written prepared testimony, and just to say that we need to be recognized.

Mr. KOLBE. Thank you very much.

[The prepared statement of Mr. Smith and Mr. Ramirez follow:]

PREPARED STATEMENT OF PASCUA YAQUI TRIBE SUBMITTED BY MICHAEL SMITH AND CHAIRMAN DAVID RAMIREZ

The following testimony if presented by the Pascua Yaqui Tribe of Arizona. The Pascua Yaqui Tribe appreciates the opportunity to enter the following testimony into the record. This testimony reflects the views of the members of the Pascua Yaqui Tribe concerning long-term health care issues for the Pascua Yaqui Tribe.

BACKGROUND

In 1978 P.L. 95–375 extended certain Federal benefits, services, and assistance to the Pascua Yaqui Indians of Arizona. The Pascua Yaqui Tribe is not served by any Indian Health Service (IHS) direct care facility nor by IHS field health staff. The direct care and preventive health services are provided to the Yaqui Tribe by a local IHS–HMO contract and a Tribal Community Health Program (P.L. 93–638 contract). Long-term health care is not however, a part of the contractural agreement.

ISSUES

Long-term health care for Indians is fragmented and ineffective. Currently long-term care is addressed in the following manner:

1. Arizona Health Care Cost Containment System—there is no provision for long-term care under the existing system in Arizona. There are no resources available and no immediate plan to address the problem. Medicaid states do have long-term care provisions.

2. Indian Health Service (IHS)—IHS policy on long-term care for the elderly allows for expenditure of contract health services funds for skilled nursing care. IHS is payer of last resort and must exhaust all revenues of alternative resources including Medicare and Medicaid before their funds may be expended. A review of IHS expenditures for skilled nursing care showed that 95 percent of those costs were incurred in the State of Arizona where there is no alternate resource for elderly care.

3. Bureau of Indian Affairs (BIA)—The Bureau policy for long-term care is a residual one for only custodial and domicillary care. In provision of non-medical institutional or custodial care the majority of services were provided for needy and eligible

residents on reservations in the State of Arizona, because the state does not administer a Title XIX program. Once again no funds are expended until alternate resources are exhausted.

4. County services—County resources are utilized by Yaqui clients if they qualify and if service is available. In most cases however, they do not meet the criteria.

5. Medicare—approximately only 10 percent of the Indians residing in Arizona qualify for Medicare reimbursement. IHS is currently experiencing billing problems with the AHCCCS program for Medicare reimbursement.

Since the inception of the AHCCCS program IHS was informed that all enrollees over sixty-five years of age were automatically flagged as being covered by Medicare. That assumption may have been OK for the general population but was not appropriate for the Indian population since very few have Medicare. The staff dealing with these problems have continued to make AHCCCS aware of the erroneous information but there has been no correction of the situation.

ADDITIONAL CONCERNS

The Pascua Yaqui Elderly have been experiencing yet another situation which is of grave concern. Since the beginning of the Diagnostic Related Groupings (DRG's) early discharge has caused a cost savings to hospitals and the HMO contract but has caused discomfort and massive confusion for placement of the elderly. In Tribes that have IHS hospitals elders may be held until provisions are made. In the case of Yaqui, clients are generally discharged to home, placing an unusual burden on already strained Home Health services. In essence the needs are still there the cost is only shifted. Home Health may be an answer but in many cases Tribal Health Departments are not Home Health Certified and although they may be required to provide the services they are unable to receive Medicare reimbursement.

There exists fragmentation of services, continuity of care, risk of inadequate quality of care because of the multiple sources of small amounts of funds requiring many agencies to become involved and not allowing for control by any single agency.

It is apparent that an increasing amount of responsibility for long-term care is being placed on the States and Counties for Indian Health Care.

CONCLUSION

In conclusion the Pascua Yaqui Tribe would like to make the following appeals:

Since Arizona consumes 95 percent of IHS long-term care resources because there is no Medicaid alternative resource it is respectfully suggested that Congress intervene to facilitate a state Medicaid alternative or provide direct supplemental funds to IHS and BIA to provide long-term care for Indian people.

It is also respectfully requested that Congress continue follow up on long-term care issues in the State of Arizona.

The Pascua Yaqui Tribe thanks you for the opportunity of allowing this testimony to be entered into the record for your consideration.

Mr. KOLBE. Would you give me your name?

Mr. SMITH. My name is Michael Smith.

Mr. RAMIREZ. Chairman Ramirez.

Mr. KOLBE. Right, and the chairman, I know, Chairman Ramirez.

STATEMENT OF DAVID RAMIREZ, CHAIRMAN, PASCUA YAQUI TRIBE

Mr. RAMIREZ. Thank you for giving us this opportunity to give this written testimony.

Mr. KOLBE. Thank you very much. The testimony will be entered into the record.

Ed Hanson, representing the Papago Tribe. Ed?

Mr. HANSON. Congressman, I would like the vice chairman of the Papago Tribe to——

Mr. KOLBE. Fine, thank you.

I have just been advised by staff that since we are still filming this, they would like to get your profiles in and that is why we

have the microphone facing the way it is there, so that we can film this.

Sir?

STATEMENT OF FRANCISCO JOSE, VICE CHAIRMAN, PAPAGO TRIBE OF ARIZONA

Mr. JOSE. Thank you, Congressman. I would like to introduce myself. I am Francisco Jose, vice chairman of the Papago Tribe. We are the second largest land based tribe in the United States.

In light of all the testimony from the people that spoke at the outset of this meeting, I would like to sympathize with them, and then you will much better understand my case. In light of the responsibility, we urge the members of—excuse me—in light of this responsibility, we urge the members of the Federal Government present here today to recognize the Indian people of the United States and the Indian Health Service, are not immune from the effects of the new Medicare system. Just as others present today will surely say that the present application of the concept of the diagnosis related groups fails to consider the needs and implications of long-term care for the elderly, we assure you that the Medicare issues in general, the State of Arizona's Medicaid Program of AHCCCS has its impacts on our elderly, as well.

It must be recognized that the Indian Health Service no longer operates in isolation. It too feels the pressures of shifting responsibilities, Federal Government's divestment in favor of increasing State obligation, and ever-increasing fiscal constraints, and so too does the Bureau of Indian Affairs.

When these factors impinge on health care delivery, the end result is a reduction of services and, perhaps, the quality of care. We cannot allow this to happen anywhere with any population segment, but most assuredly, we must not allow these efforts to responsibly manage the Federal Government to overshadow our more basic responsibility to care for our elders. We, the Papago people, hold the elders of our tribe in the highest esteem, and believe this is a consistent principle among all social and ethnic groups in the United States. Therefore, we ask that when you review the testimony provided to you today, that you consider the implications seemingly unrelated issues will have on the Papago and all Indian people.

We are now affected by the Medicare system, but its impact on federally operated and maintained health care delivery systems. In the future, we anticipate the Federal Government will increase its demands on the State governments. We ask that you reflect upon the degree to which the AHCCCS program plan provided adequately for long-term care. Were the individual counties prepared to provide for long-term care not covered under the AHCCCS program? It is too moving to operate within the scope of Medicare rules and regulations.

What are the implications of this on Native Americans? Will their esteemed elders be adequately provided for under this system? We remain concerned because even now we cannot provide for the elderly in the fashion which we would like.

Mr. KOLBE. Can I ask you to submit the rest of it or just finish up with the conclusion, there, please, because you have gone more than 2 minutes.

Mr. JOSE. OK. We have some questions that we would like you to address, and that is: Is there a conceptual overview of a cycle for the continuum of care for patients under the Medicare system? Does it include a reasonably functional method for ensuring the provision of long-term care? Does clearly defined policy exist for the insurance of service when multiple State or Federal agencies are involved, for example, AHCCCS, Indian Health Care Service, and the Bureau of Indian Affairs? And are the specific obligations and responsibilities clearly delineated?

Mr. KOLBE. Thank you very much, for that. If you give us that copy, we will include it.

[The prepared statement of Mr. Jose follows:]

PREPARED STATEMENT OF THE PAPAGO TRIBE OF ARIZONA

The Papago Tribe of Arizona enjoys the distinction of being the second largest Indian Tribe in the United States with an enrolled population of 17,651. At the same time its total acreage of 2,855,969 makes it the second largest land mass reservation in the United States. These facts are important in consideration of the plight of the aging population in our country today because our sheer size and land base give sound examples of the numerous problems surrounding the provision of health care to our elderly.

We, as representatives of the Papago People, are here to provide testimony in order that it be clearly established, for the record, that we are concerned about the elderly persons within our Tribe, for whom we feel a moral and ethical responsibility.

In light of this responsibility, we urge those members of the Federal Government present here today to recognize that the Indian People of the United States and the Indian Health Service are not immune from the effects of the new Medicare payment system. Just as others present today will surely say that the present application of the concept of diagnosis-related groups (DRG's) fails to consider the needs and implications of long-term care for the elderly, we assure you that Medicare issues in general, the State of Arizona's "Medicaid" program of AHCCCS has it's impact on our elders as well.

It must be recognized that the Indian Health Service no longer operates in isolation. It too feels the pressure of shifting responsibilities, Federal Government disinvestment in favor of increasing State obligation, and ever-increasing fiscal constraint. So too does the Bureau of Indian Affairs. When these factors impinge on health care delivery the end result is a reduction of service and, perhaps, the quality of care. Certainly, we cannot allow this to happen anywhere, with any population segment. But most assuredly, we must not allow these efforts to responsibly manage the Federal Government to overshadow our more basic responsibility to care for our elderly. We Papago People hold the elders of our Tribe in the highest esteem, and believe this is a consistent principle among all social and ethnic groups in the United States.

Therefore, we ask that when you review the testimony provided to you today, you consider the implication seemingly unrelated issues will hae on the Papago, and all Indian People. We are now affected by the Medicare system, by its impact on Federally-operated and maintained health care delivery systems. In the future we anticipate that the Federal Government will increase its demands on the State Governments. We ask that you reflect upon the degree to which the AHCCCS program plan provided adequately for long-term care. Were the individual counties prepared to provide for long-term care not covered under AHCCCS? Now the Indian Health Service is being mandated to maximize the use of the AHCCCS, it is moving to operate within the scope of Medicare rules and regulations. What are the implications of this on Native Americans? Will our esteemed elders be adequately provided for under this system. We remain concerned because even now we cannot provide for our elderly in the fashion we would like.

For many years we have worked to put a nursing home, a facility for long term care, on the Papago Reservation. There are thirty six (36) Papago Elderly placed in off-reservation nursing homes because of the lack of an on-reservation nursing home

facility. An average nursing home placement being approximately two hundred (200) miles removed from the reservation. And there are many, many more of our elderly needing placement and a greater number who would benefit from a nursing home facility but, continue to refuse being moved from their reservation homes. To date these efforts have not been successful, but at least we understand what the game is all about. On the other hand what does our increased involvement in the Medicare and AHCCCS hold in store? Will the system create more victims, as a result of incomplete planning and consideration.

It is clear to us there is a gap in service to the elderly under the existing system. We find ourselves being impacted on more and more by this system. Therefore, we ask as part of public record, that as the Select Committee on Aging, through it's Health and Long Term Care Sub Committee, looks at Medicare and its impact on the elderly populations within the United States it recognize that Native Americans, previously outside that system, have now been drawn in and must be considered as an intrinsic part. Effective problem identification and program planning must include consideration of Native Americans in order to be complete.

Some questions which must be addressed from the outset include:

Is there a conceptual overview of a cycle for the Continuum of Care for patients under the Medicare System?

Does it include a reasonably functional method for ensuring the provision of long-term care?

Does clearly define policy exist for the insurance of service when mulitple state and/or federal agencies are involved, for example AHCCCS, Indian Health Service, and the Bureau of Indian Affairs (BIA)?

Are the specific obligations and responsibilities clearly delineated?

In July of 1985 the Pritglaff Commission on Long Term Care released a report which deals with the provision of long term care in Arizona. The report makes clear the necessity for Indian Tribal governments and the Arizona state government to cooperate in assuring that federal funds are available to tribes to provide community and in-home services to elderly Indian reservation. We encourage you to pursue this as an extension of the continuum of care, post-acute care hospital stays in-light of DRG's and reduced lengths of stay (LOS).

That same report recommended the establishment of screening and case management mechanisms. The state and/or counties would screen people for placement in nursing homes and Medicaid financing. If the State or counties do the screening, it may end up in a situation similar to AHCCCS, where the Indian Health Service forces people to apply to the counties for nursing home assistance, and threatens to terminate Contract Health Service payments.

It is important that Indian tribal governments, the Arizona state government and the federal government (IHS) work cooperatively to insure that Medicaid dollars are available to Indian nursing home patients without jeopardizing the health or well-being of those Indian patients.

On behalf of the Papago Tribe , thank you for the opportunity to testify. We urge you to consider the needs of more than 17,000 concerned citizens of Pima County and the State of Arizona. But perhaps more importantly, we urge that you look at the current system for its impact on all Native Americans who seek health care under a system directly and indirectly impacted on by Medicare. We care for our elderly and hope, always, to provide for them so that they might live with dignity.

Mr. JOSE. Thank you. We appreciate it.

Mr. KOLBE. Thank you very much.

Esther Barr and Jackie Kechnic?

STATEMENT OF JACKIE KECHNIC, COUNCIL HOUSE

Ms. KECHNIC. Right. Council House is a federally funded housing for elderly and disabled, and we have 165 residents. After listening to the testimony, I was not here all day—I feel we do have some problems with early discharge.

I have four people within the last 90 days whose whole lives turned around. One of them died at Council House under home health care supervision. And I would hope that maybe we can do a little more research into this area and find out what actually is happening, when they go home so that maybe in some way, we can

rectify this. Because it does change an elderly person's life and hopefully get some more interim care.

Mr. KOLBE. Thank you very much.

Let me emphasize if you do not have written testimony, and you would like to submit it, the record will be open for you to submit that in writing.

Warren Scriber, representing Independent Insurance for Home Care.

STATEMENT OF WARREN SCRIBER, INDEPENDENT INSURANCE FOR HOME CARE

Mr. SCRIBER. Congressman, thank you for this opportunity.

I am disturbed that the insurance industry, the financial picture involved in this was not discussed as a panel problem. How are each of us going to pay for these particular specific benefits that we get through skilled nursing homes, private duty nurses, and so forth?

I am suggesting to you that Medicare could address this area in providing a particular program to readjust Medicare to take care of skilled intermediate and custodial care, and to take care of private duty nurses.

My suggestion to you, first of all, is to change Medicare to the existing—everyone is ineligible, of which it is not. At the present time, less than 2 percent of the admitted individuals into nursing homes, are accepted under Medicare. 98 percent of these people have no funds coming from Medicare to pay for their skilled nursing home, and to add private nursing at home as an additional benefit under Medicare.

The skilled nursing home and private nurse at home would have a limited period of time for benefits. Can this not be a carte blanche arrangement in that Medicare supplement programs through the insurance industry would take over to pay on for a limited period of time, such as 3 to 5 years, and that would be afforded for individuals who could afford the type of program?

Nonqualified for Medicare and those who could not afford Medicare or Medicare supplements programs would have their benefits paid by a special fund under Medicare.

A way of funding this would be to increase Social Security deduction for workers and to deduct some Social Security income possibly from paying on a sliding scale from individuals. And I think this issue should be addresssed.

Mr. KOLBE. Thank you very much for that, and if you have anything in writing, we would be happy to have that also.

Now, for other members of the audience, if you would just come up to the microphone and please be sure that you identify yourself by name, and who you are representing, there and we will limit it to 1 minute.

Elaine.

Ms. OWENS. As Mr. Grabel and Mr. Kolbe—for me to sit and not for 4 hours, is like Chinese water torture, especially when it is so close to my heart.

Mr. KOLBE. For the record, please begin by identifying yourself.

Ms. OWNES. Elaine Owens, as a private citizen.

Mr. KOLBE. Thank you, Elaine.

STATEMENT OF ELAINE OWENS

Ms. OWENS. I did not come as anybody's employee today. I came as Elaine Owens, nobody's employee today.

I came as a person that for 10 years has been trying to take care of the elderly. And if these people have not had any complaints, I do not know. It is because we did not know where to go to, because in the last 6 months, I have had five and when our nurse took me down to take care of a lady's scar that went from here to here, 8 inches long, 3 inches deep, 2 inches wide, my mouth fell down to here. And if they said that is not a too soon discharge, I don't know where they have been.

I did not have any of those in the last 10 years, and I have been taking care of these elderly people. And the hernia lady was mine that I had to take home to an empty house with no family, and nobody to take care of on an afternoon. And I am the bag of cement that has to—you know, fill these cracks. Then we are the online people that have to take care of them.

I also run a nutrition site where they come to me and say they have to have two more of my meals, which means I have to tell two more of my people that they cannot come and eat there today. And that is where we are really talking serious business. And we are talking about an interim of care between the hospital and when you send them home to us, because we do not have the care there and so we have to have that interim care. And they are coming home sooner and sicker. And I am going to quit before bang that gavel.

Mr. KOLBE. Thank you, Elaine. You did it just right. I appreciate that.

Ms. NIEMAN. I am Evelyn Nieman, and I only have a question about PRO. What are their duties? How did Dr. Shapiro get his job; And how was he appointed?

Mr. KOLBE. I think the answer to the question is that it is a contract, an organization with which HCFA contracts, so there is in a sense a bid process by which they become the peer review organization.

Jim Murphy.

STATEMENT OF JIM MURPHY, DIRECTOR, PIMA COUNTY'S DEPARTMENT OF AGING

Mr. MURPHY. Jim Murphy, director of Pima County's Department of Aging and Medical Services. And I am so pleased to hear so much conversation today about continuum of care and case management, because we have had that system in Pima County for 10 years. Unfortunately, it serves very few of the population that have a need.

We have been impacted in Pima County greatly in our nursing home park where we care for 1,170 individuals, and we have had to increase staff. It has been more costly and yet only about 1 percent of the population of our 1,170 on any day are having Medicare benefits. So, the local taxpayers are paying much more for this care in nursing homes, as a result of a cost shift from the hospital.

In our community services case management system, we have been as they have in Cochise County, and all over, a much greater impact and demand for services where there is no payment. I suspect that since there is payment in the skilled care area, that there is an improper use of skilled care, because there is a payment mechanism that people are ordering skilled care where lower-level services could suffice but there is no payment mechanism for it. We have more emergency meals. We have elderly people discharged who live alone, or who have a spouse who is equally disabled and cannot, as Ted Koff and many others said, do the things necessary to take care of themselves.

We do not have title 19. Every other State in the Nation has Medicaid dollars to help support many of the programs but in Arizona, we do not.

I would like to call, if I could, on Jill Bemis from my staff. We say we do not hear of any cases. We have many, many, many cases and this is just one case where the system did not work.

Mr. KOLBE. Thank you, Jim. And we will—I want to say thank you for the work that you have done, and for the help that you have given me. I, through the years, have worked with you on the legislature on these issues. They certainly are ones that I think we have all grappled with, and your testimony will be made a part of the record.

Ms. Bemis?

STATEMENT OF MS. BEMIS

Ms. BEMIS. This will be a short 1 minute. This is one of about 1,700 cases we have open today. It is an 87-year-old woman on a limited income of $480 a month, who was hospitalized in May 1985, for 4 days. The diagnosis was pneumonia, emphysema and arthritis. Prior to admission, she had been wheelchair bound but able to transfer herself. She is the sole caretaker of a 50-year-old retarded son, and has no other support system.

When discharged home, there was no referral made for any home support services. Yet, she was so weak that she could not transfer and was seriously undernourished. Following a continued deterioration in her condition, she was rehospitalized 2 weeks later with a diagnosis of severe respiratory problems, malnutrition and dehydration. She was discharged 3 days after that, and this time with a referral for Medicare covered home health three times a week.

A case manager was called by the home health agency, recognizing that this was not going to be adequate and a whole package of services were immediately authorized, including home-delivered meals, shopper, personal care, laundry, housekeeping and assistance with transferring to the bathroom. These services, although completely inadequate in frequency because of our extremely limited resources, helped to stabilize her and let her remain at home this time, but taking many, many months to recover because she had become so seriously debilitated.

Of all the care she received, only the three times a week visit for skilled nursing was covered by Medicare. Everything else was covered by local resources.

Mr. KOLBE. Thank you, very much for that case history. It certainly is food for thought.

STATEMENT OF GERALDINE LEACH, ELFREDA AND COCHISE COUNTIES

Yes, ma'am?

Ms. LEACH. Hello. I'm Geraldine Leach from Elfreda and Cochise County.

My mother died a week ago today at the Cooper Green Community Hospital. Around Labor Day, she was attended by some incompetent aide of some kind, and she said that she had banged her up. And she hit her on the head. And she said later that her neck hurt where the neck joined the head, and she had a sore throat. And she said that the aide shook some kind of dust in her face. So, through the hospital, I checked and double checked for personnel they hired. I went to the personnel department to ask about that aide, and the girl in the personnel department said that she had never seen such a person. And I went to find the head nurse who hired her. And she was not available for comment. And I tried to find my mother's doctor, Dr. John Abbott, and he was out of town.

So, I was wondering how well the hospitals check on their people before they hire them? That is all.

Mr. KOLBE. Thank you for your comment, and that certainly is a good question. And I know that hospitals do try obviously to check on them, but I think there are times when we can never be too careful in terms of the kinds of people we hire. I certainly think that is something for you to take up with either the administrator of the hospital or with appropriate review groups in Cochise County.

Are there other comments from the audience? We will take two or three more.

STATEMENT OF WILLIAM SCOTT, BOWIE, AZ

Mr. SCOTT. My name is William Scott, and I am from Bowie, AZ.

Mr. KOLBE. Thank you for coming, sir.

Mr. SCOTT. Some of this has been covered today in this deal, but I have a wife that has Alzheimer's disease, and we are both retired. I am 76, and she is 73. And she is unable to take care of herself. And I am a heart patient for over 40 years. I have been in and out of the hospital, and I have a lot of expenses. And our savings is very, very limited. I had to keep my wife—I cannot take care of her anymore because she has no control of her bowels or her water, or cannot feed herself. She can hardly walk, and so I got to the point where I couldn't take care of her anymore, and so I had to put her in a health care home. That costs me $1,200 a month. I have $1,300 for pension, and that is all I have, and Medicare, but none of that pays anything. And I am in bad need of help somewhere because my savings is about gone.

Mr. KOLBE. Thank you very much, sir. We just completed a hearing in Washington before the full select committee on Alzheimers, and the way in which it can totally devestate families financially. And I wish I had a simple answer for you. But I think it is one that

we, as a nation, and certainly in Congress, are going to have to address.

There is—at least you will be happy to know, a good deal of attention being given by several committees to this problem.

Alzheimers is just something that many of us are just discovering as a problem. We really have not, in the past, we just said "senility." We are now discovering that it is a real illness and something that really needs to be addressed. And I appreciate your bringing this to our attention.

STATEMENT OF DR. MCCLAIN, PATIENT AND FAMILY SERVICES, TUCSON GENERAL HOSPITAL

Dr. McCLAIN. My name is Dr. McClain, and I am with patient and family services of Tucson General Hospital. And I felt like something needed to be said for the social workers.

Mr. KOLBE. Thank you for saying something for the social workers.

Dr. McClain. We have heard a lot of things about discharge planning and the social workers, and I'd like to stand up for them today, if I could.

I give 10 hours a day, working with patients in a hospital, work at night, people call me at home, and it is very, very hard to make sure that patients have something when they leave the hospital. I realize the DRG system is in, but I work very closely with all the case management agencies in town, and with the home cares, and I know it is not sufficient, but we really work hard with the families and with all the agencies to at last provide something for the patients when they leave the hospital.

So, I just did not want social services to just go down and discharge planners thinking that we do not do in the hospitals because we really do. We do not always have open referrals because it is the doctor that has to give the referral. But we work as hard as we can to get the help for the patient in the hospital.

Mr. KOLBE. Thank you very much. And thank you for the work that you do on behalf of patients who are being discharged. We appreciate it.

Yes, ma'am?

STATEMENT OF EILEEN GLICKMAN

Ms. GLICKMAN. My name is Eileen Glickman, and I have spoken to you before about the VA hospital system. The fact that it is being cut down, which will, could take—which will throw a lot of older patients onto the Medicare system when it should be increased so that we will take the problems off Medicare and there are a number of hospitals for long-term care, and they get excellent care, and they also are doing the most research on Alzheimer's disease than any other hospital in the country. I believe it is in California, and they have facilities to do it, and try different medications to see if we can help this problem out.

Mr. KOLBE. Thank you very much.

Ms. Knowles?

Ms. KNOWLES. Congressman, I cannot use the microphone because I do not want to talk over there.

Mr. KOLBE. OK, just——

Ms. KNOWLES. But there is one message I want to give you. Those that are younger, here, if you do not want to die young, you are going to end up joining us—all we ask of you—it looks like we are making a lot of demands, but there is no place else we can go. Please, work, and do your best to let us live our last years in dignity.

Mr. KOLBE. Thank you, Catherine. I think that is certainly an objective and a goal that all can adhere to and one that we can all strive to reach. And I want to thank you for that comment.

Yes, sir?

Mr. CLARK. Alan Clark, of Cochise, AZ.

I have a statement to be made, but it is contained in the envelope that I mailed to you.

Mr. KOLBE. Would you like that contained in the record?

Mr. CLARK. I want to ask this young lady a question. Can you tell me what the mechanism that caused the closure of the care facility in Sunsachs, AZ?

Thank you.

Mr. KOLBE. Thank you for your comments, and your question. I wish we had the answer that you wanted.

Do we have any other comments? All right. We will take two more. One—then one more if there is one—whoever gets up to the microphone first.

Yes, ma'am?

STATEMENT OF JO KLINE

Ms. KLINE. I am Jo Kline, private citizen. The question repeatedly asked especially by Mr. McCain was, have you been educating the people about this problem? What are you doing to help them?

I am an educator. It is very difficult to educate people on this. I get the material. Who reads it? I do not need it. Why should I read it? Or you glance through it. And you do not retain it.

The young people think they are never going to get old, and they are never going to get old and sick. The middle aged people think, yeah, maybe I may get old, but I am not going to get sick, and then you get a little older—yeah, I am going to get a little older, and I might get sick, but Medicare and my personal insurance will take care of it.

The insurance man said, why did not we worry more about private insurance and discuss that. As part of the school system, we get to revise our insurance every year about this time, as the school system starts. I went down to revise or check my insurance and everything went up and one particular insurance company went up double of anybody else, and then some. Well, over $140 or something like that per month per individual. I asked them how come you went up so much, and you are so much more than anybody else. "Oh, we revised our statistics. We now separate the young from the old. And the older and getting sicker, so we just did the statistics for them." What good was having an insurance plan that was supposed to balance out everything?

We made it easier for the young people and a little less expensive and more for us. So, none of these things solved the problem.

If I knew how to educate people—whether it is a child—how can you tell one person that you are going to need this math or this thing when you get to be 30 or 40, or the next job, and you cannot tell people this, either. So, you keep saying, hey, we are not telling enough people. I will bet anybody that is here that the reason they are here is because they had some personal contact. They either work in the field or they had a parent, a brother, a sister, a spouse, somebody who was sick and until this happens, you do not realize the problems and then it is too doggone late.

Mr. KOLBE. Let me say, thank you very much to everybody that has testified today, to those on our panels to the staff that prepared this, to St. Joseph's Hospital for their hospitality, and most of all, to the audience who patiently listened to this and gave us their valuable input.

As I listened to this, I certainly came away with some idea of things that we need to do in the future and one of them, is that we need to have another hearing on the subject of that continuum, on what kind of health care services are going to be provided after discharge from the hospital. That is clearly, regardless of DRG's, as the population ages, going to be a continuing problem and one that I think the Congress and our society needs to address. And I hope that we will have another hearing on that some time in the near future.

Again, thank you very much for being with us, today. We appreciate it.

The hearing is adjourned.

[Whereupon, at 1:37 p.m., the hearing was adjourned.]

○